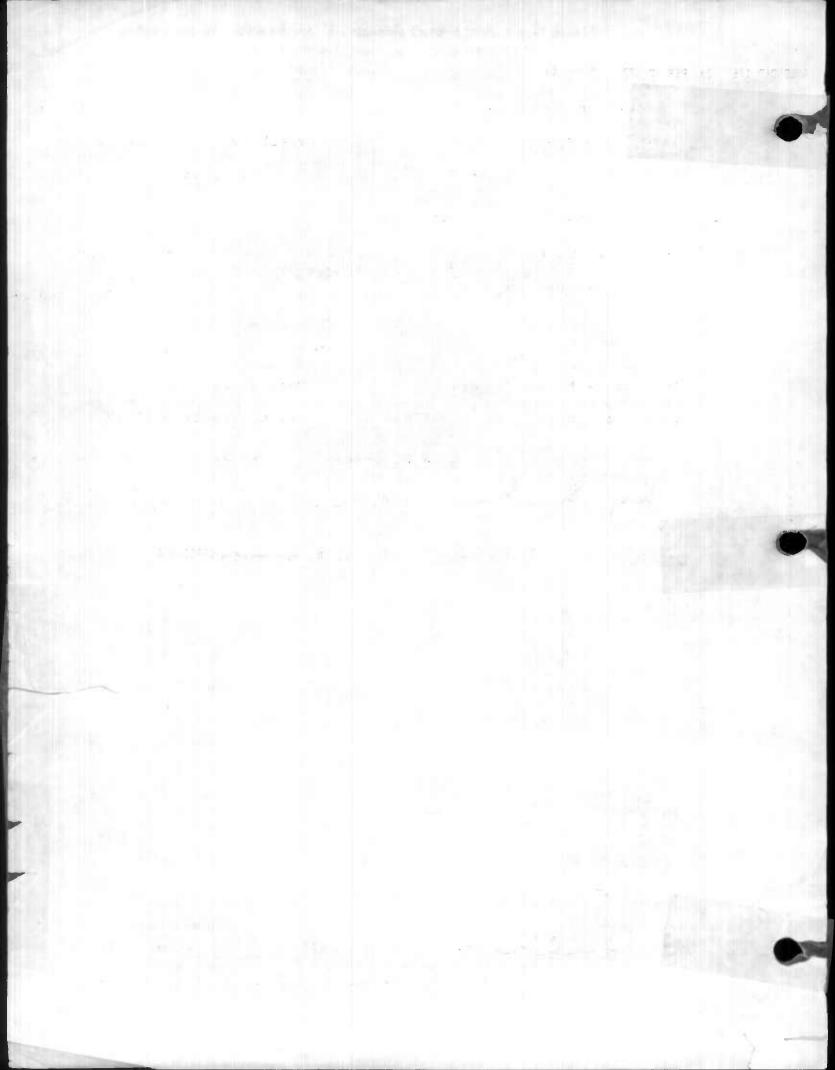
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DHMH 16 Rev 6/95

Registrar



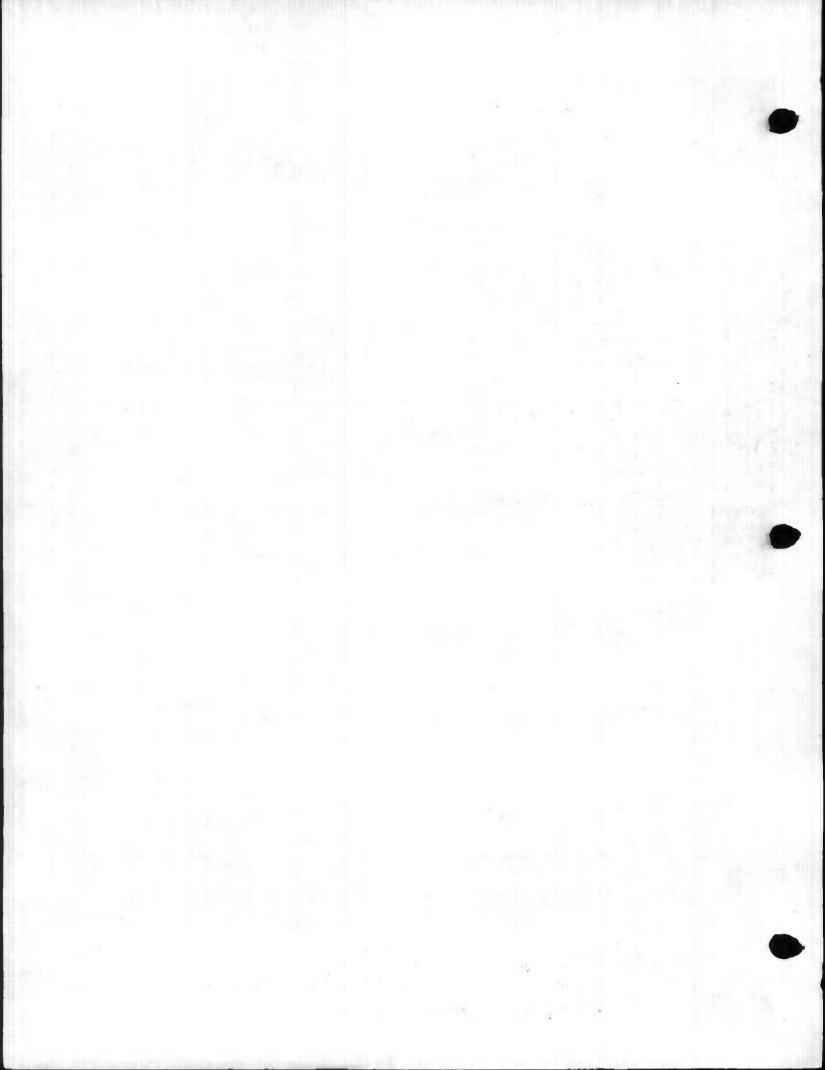
		State o	of Maryland		artment of	Health and I		ene 9 (9 2	6502
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/Medical Examiner	4a Facility Name (If not institut			1	ay 101	4b. City, Town, or i		4c. County		11.55 IM
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	st only one cause on e	sech line.	,		Cance			V	Intervel Between Onset and Death
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

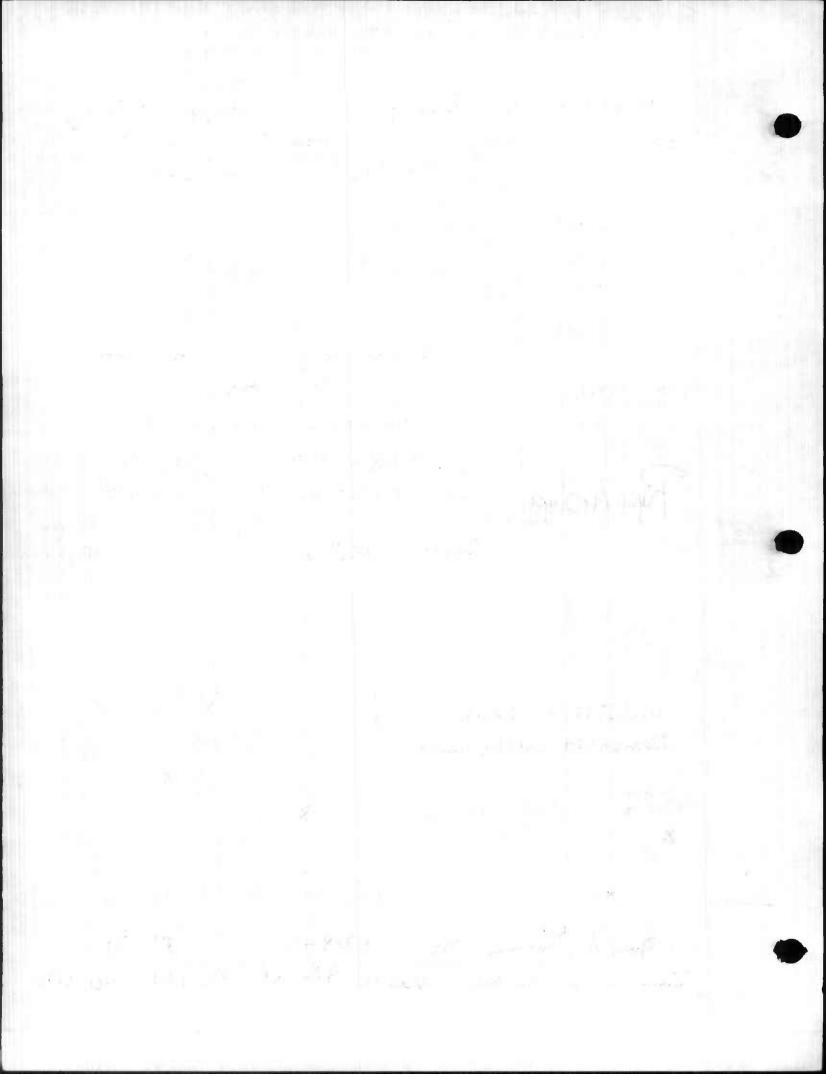
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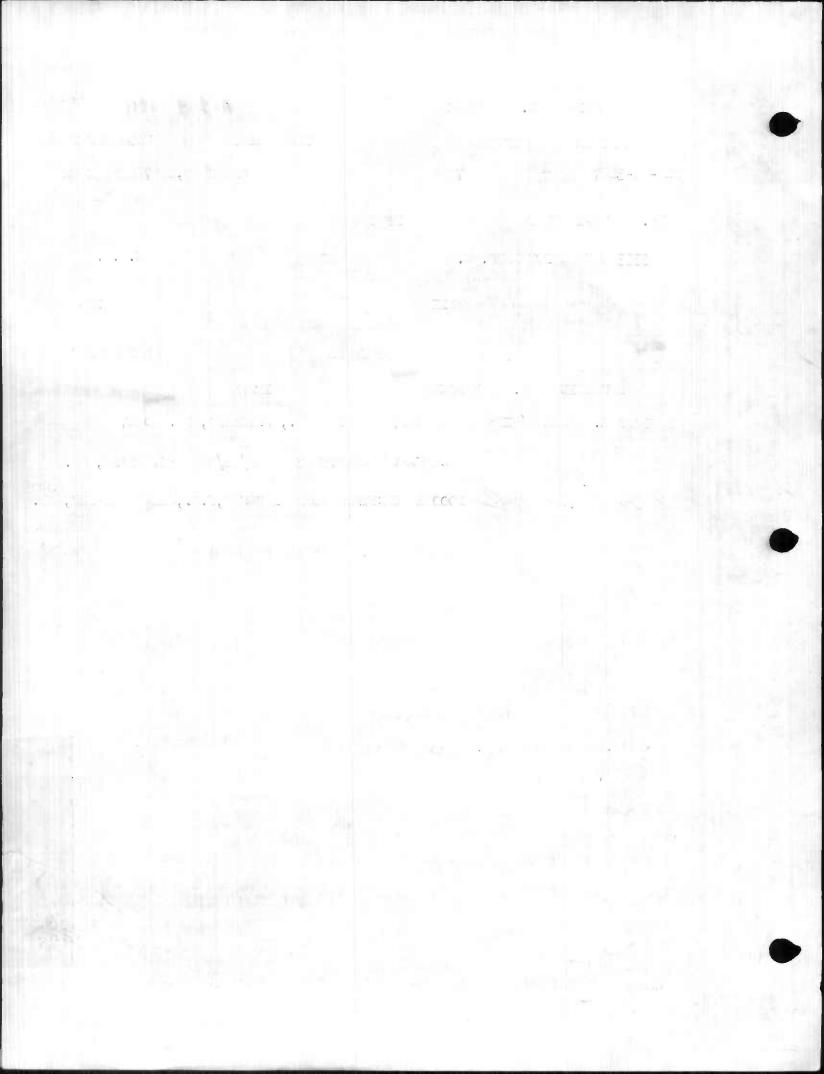
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, 1999 Harvey **Physician** Phillip lobery 7:20AM August /Medical 4a. Facilify Nama (If not institution, give streat and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Health Care Center Frederick Frederick 5. Social Security Number If Undar 1 Year | If Undar 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1**X**0M 2□ F Months Days Hours Yrs **Director** 214-10-3049 89 Oct. 16, 1909 Maryland Usuei Residence of Decedent death with the Maryland 10a Stata 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Middletown 10f. Zip Code 10g, Citizan of What Country? 21769 18 Linden Blvd. Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Depentment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". A sany injury or other traumatic event. items : 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 4 Yaar or Dates: 11 Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Americen indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 owner/operator meat market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Charles Tobery Annie Tobery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Tobery, wife 18 Linden Blvd., Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurlal 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) Frederick Mem. Park at 8/10/99 Frederick, Maryland Linden Hills and Address of Facility Keeney and Basford Funeral Home 2 Signatur of Funeral Service Licensee 106 East Church Street, Frederick, MD 21701 M00999 ise, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, it is tonly to be cause on each line. Approximete Intervai Betwe Onset and Death Physician /Medical immediate Cause (Final C.a. Pin 10 years disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Diubetis mellitus 1 Yas 2 No 3 Probably 4 Unknown of Vital Records, ģ Completed Dementia altaheiners 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of deeth? After this certificate has 2 X No 1 Yes 2 No Attending Physician: Be 25. Was cese raferred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 No spital or Attending Physi hours efter death. nerel Director: After this in tilled in by the funeral di 27. Manner of Death Certification: 28b. Tima of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital o within 24 hours of To the Funeral D completely filled in Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title ot certifier 29c. License number 29d. Date signed (Month, Day, Year) 746720 My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK, MB, 21701 5, GriTton 300 W Mil 31. Date filed (Month, Day, Year) 40G 1 0 1999 32. Registrar's Signature State Registrar



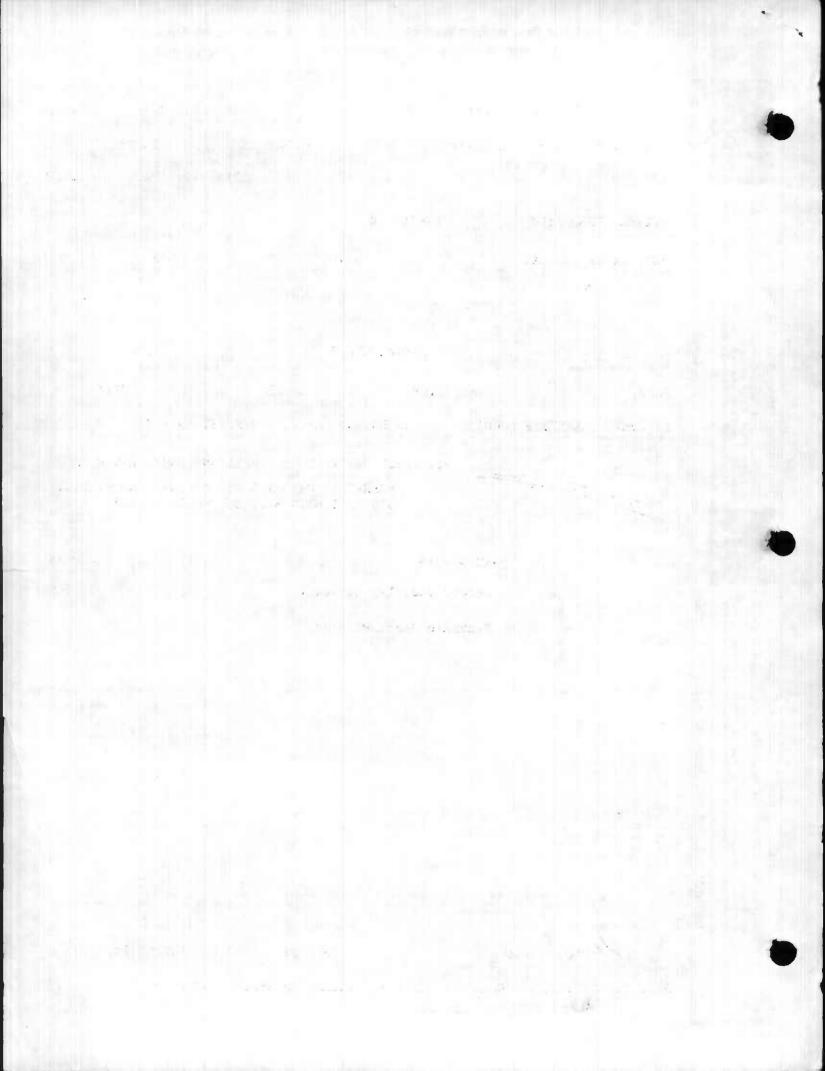
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ysician Iedical	1. Decedent's No	ame (First, Middle, Last, AGIS		LAKOS	5			2. Date of Dea Month	Day 19	Year 9	3. Time of Deeth
niner	4a Facility Name	(If not institution, give	street and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	
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r	5. Social Security 119-14- Usual Residence	3187	M 2□F	72		Months Days	Hours Min.	8. Date of Birth (Month, Day MARCH 2	y, Year)		place (State or Foreign http) YORK
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tor	MD.	MONTGOME	RY		KENS	SINGTON					1 No 2 No
Directo	10e. Street and I	Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
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by Funeral		s arried 2 Merried d 4 Divorced	12. Wes Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:		10	s Decedent of Hes, specify Cuba	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Rac Bled Specify	k, White,	can Indien, etc.
		15. Decedent's Edu	cation		16a. Deceden	it's Usual Occup	pation	line	16b. Kind of Bu		
Completed	-	eccify only highest grade econdary (0-12)	College (1-4or :	5+)	life. DO	NOT use retired	during most of worl d)	king	ENG	TNEE	RING
Bec	17. Father's Nem	ne (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Sumam	10)	
To		DEMETRIUS	E. V	ALAKO	S		IR	ENE	GEN	NARO	S
		Neme/Reletionship (Ty					and Number or Ru				Code)
		RA K. VALAK	OS/WIFE	DOL DI	6417		DR., BE	-		-	0
	20a. Method of E	Risposition 2 ☐ R	lemovel from State			fory or other pla	ce)	Date	20c. Location -	City or 10	own, Stete
		n 5 ☐ Other (Specify)		CH	AMBERS	CREMAT		8/11/99	RIVER	DALE	, MD.
	21. Signeture of	Funeral Service License	bersal	MOOC		AMBERS E	SS of Facility FUNERAL H	OMES,P.A	.,SILVE	R SP	20906 RING, MD.
	23a. Pert1. Ente shock, or h	or the disease, or comple eart feilure. List only or	ications thet caused ne cause on aech li	d the death	. Do not enter t	the mode of dyir	ng, such as cardiac	or respiretory er	rest,		Approximete Intervel Between
	Immediate Caus disease or cond	ition	As	SPIR	ATTO	N PI	VEUM	ONIA		1	Onset end Deeth Month
	resulting in deat			Due to (or	as a conseque	nce of):				1	
Examiner	Sequentially list if any, leading to cause. Enter Ur Cause (Disease	conditions, immediate inderlying)	Due to (or	as a conseque	nce of):					
Medical	that initiated eve resulting in deat	nts)	Due to (or	es e conseque	nce of):				1	
and			1							-	
Physician/M	1	nificant conditions cor					ven in Part I.	23b. Did 1	lobacco use co	ntribute t	o the cause of death?
by Phy	Co	NGESTIVE OSTRIDU	3 HRM	可 F	ALLUR	屋		10	Yes 2□ No	3 □ Pro	bably 4 Tnknown
Completed				PICIL	B CO	LITIS			an autopsy med?	av cc	fere autopsy findings vallable prior to ompletion of cause death?
EO.	5:	BIZURES	, >					101	ras 212No	1[□Yes 2□No
Be	25. Was case re examiner?	ferred to medical					26. Place of Dea	th (Check only o	ne)		
10	1 Yes 2	eath 5 Pending	lospitel: 1 Inpatie 28a. Date of Inju (Month, Da	iry	ER/Outpatient 28b. Time of Injury	3 DOA Oth	4 Li Nursing n	ome 5 ☐ Resid	dence 6 Oth		(y)
Certification:	2 Accident 3 Suicide 4 Hornicid	6 ☐ Could not be	28e. Place of Inj building, et	ury - At ho c. (Specify	me, ferm, street)		165 2 2 10	28f. Location (5 City or Tox		er or Run	al Route Number,
edical C	29e, Certifier (Check and)	15 Cartifying Phys		f examinati							
×	-	of title of certifier				29c. Licens	se number		29d. Date signe	d (Month,	Dey, Year)
	N/3	604				Da	28656		Augu	ST	9 1999
1	30. Name and	identitis of playson who co	mpleted cause of d	leath (Item	23a) (Type Pri	int)	456			_/	1
	RAN	1 · 1/18/81	MD 8	609	SECON	ND A	WE,#4	04B	SILVER	SP	PEING MODAL
State strar	31. Date filed (M	onth, Day, Year)	32. Registr	ar's Signat	LIFE LA	Ann Va	11				



State of Maryland / Department of Health and Mental Hygiene

Decedent's Neme /	First, Middle.	Last)			tificate of		2. Date of De	Reg. No. eth		3. Time of Death
							Month	Day	Yaar	0.10
				-		4h City Town or I		-	. of Dooth	9:10pm
raciity Name (ii n	or mismunon, g	giva street and numb	91)			4b. City, Town, or E	ocation of Death	4c. Count	y or Death	
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Social Security Num	nber 6		Age (in yrs. i		Months Days	Hours Min.	8. Dete of Bir (Month, Da	th y, Year)	9. Birthplac	ca (State or Foreign v)
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			10a Cibi	Town or Lo	nation				100	1. Inside City Limits
e. State	ob. County		Too. Only	, rown or Lo	Cation				100	
ARYLAND	FREDER	ICK	F	REDERI	CK					1□ Yes 2□No
e. Street and Numb	er				10f. Zip Coda		- 9	10g. Citizen of	Whet Country	y?
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		1 Yes 2	□ No	1			rnoan, ato.,			
15	5. Decedent's	Education	WW I	16e, Deced	ent's Usuel Occup	pation		16b. Kind of E	Business/Indu	stry
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	rst, Middle. La	st)		001.04		18. Mother's Nerr	ne (First, Middle			
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e. Informent's Nam	e/Helationship	(Type, Print)		19b. Mellin	g Address (Street	and Number or Hu	rai Houte Numb	er, City or Towi	n, State, Zip C	(OGB)
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		Removal from Ste	C	aca of Dispo ame <i>fery, cr</i> en	sition (rvama of natory or other pla	ca)	Dete	20c. Location	- City or Tow	n, State
				TARO	R CEMETE	RY 8	/11/99	ROCKY	RIDGE.	MD
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1										P.A.
3a Daul Enter the	disasso or or	malications that sau	cad the death	Do not ant	15 EAST	MAIN ST.,	THURMO	NT, MD	21788	Approximate
shock, or heart f	ailure. List on	ly one ceuse on eec	h line.	. Do not am	or the mode or dy	ng, daon as daraide	or roophotory a	,,,	1	nterval Between Onset and Death
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examiner? 1 Yas 2 No Nenner of Death Naturel Accident	Invastigat	ton 28e. Plece of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office			wn, State)		
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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #19 PER F.H. G775 9-18-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death August 6, Dey 1999Yeer **Physician** Margaret Flora Cuthbert Wittich 6:40 PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Silver Spring Bedford Court Nursing Center Montgomery County If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) March 31, 9. Birthplece (State or Foreign Country) 5 New York 5. Sociei Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1□ M 2□ F Yrs. 108-30-1954 84 1915 Director Usuel Residence of Decedent with the Marylend 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Medical Examines must be notified at 1 ☐ Yes 2 XNo Director Montgomery Derwood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18012 Mill Creek Drive 20855 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mohal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, the Mohal Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American indien, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 ☐ Yes 2 MNo if Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Self Employed Boating Business 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Alexander Biggar Cuthbert Margaret Schopp 193 Informent's Name/Reletionship (Type, Print)
JUDITH MCLEOD

Judy McCleod - Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18012 Mill Creek Drive Derwood, MD 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/11/99 Ocean View Cemetery Staten Island, NY 22. Name end Address of Fecility
Capitol Funeral Service, Inc. 21. Signeture of Funerel Service Licenses JU 7211 Lee Hwy Falls Church, VA 22046 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, of heart tellure. List only one cause on each line. Approximete Intervei Between Onsel end Deeth **Physician** /Medical Immediete Ceuse (Final Branco Pneumania disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be axecuted attending physician end for use as the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): resulting in deeth) Lest ed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy tindings eveilebie prior to completion of cause of death? 24e. Wes en eutopsy performed? Care Srovascular Accident has e 2 20 No 2 PINO 1 Yes 1 Yes certificata Division of Vital or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Dete of tnjury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident within 24 hours after deeth To the Funeral Director: / complataly filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) To the within 2 To the 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year) 33357 95 30. Neme and address of person who completed cause of deeth (item 23e) (Type, Print) 5530 Wisconsin Are Chery Chase MD Jonathan win Musher 31. Dete filed (Month, Dey, Year) AUG 1 1 1999 32. Registrer's Signeture

Jenewa

Registrar **DHMH 16 Rav 6/95**

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death LYOIA M. WHARTOW Month **Physician** 1999 AUGU ST 0520 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL ROSETTER A MONTGOMERY 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. Birthplaca (Steta or Foraign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Hours Yrs Director 98 216-46-2932 February 22, 1901 Pennsylvania Usual Residence of Decedent worle 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Marylais! Hygiene.
other than "natural", or items 23s or 28s-f show vant, the Medical Examiner must be notified at 1 X Yas 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 11005 Rosemont Drive 20850 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 12 No If Yas, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Bleck, Whita, atc 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. ð 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be filment of Health and Mental Hant: If Itam 27 la marked oth jury or other treumatic evan 8 2 John Koller Cecelia Jacques 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) Joseph F. Ferraro/Nephew In Law 1127 Bluebird Drive Munster, Indiana 46321 20b. Place of Disposition (Nama of cemetery, cremetory or other piece) August 9, 1999 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata permit. Pege Department of Important: If any Injury or 4 □ Donation 5 ☑ Other (Specify) Entombment Parklawn Memorial Park Rockville, Maryland 21. Signeture of funeral Service Licensee

ROCKVIIIe, Maryland
ROCKVIIIe, Maryland
RODERT A. Pumphirey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,
Approximate Onset and Daath **Physician** ARTEHOSCUTROTIC CARDIONOSCULAR OBRASE /Medical Immediata Cause (Final diseasa or condition rasulting in death) Examiner Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): edical Dua to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 No 1 Yas funeral director, Attanding Physician: 25. Was casa rafarred to medical axaminer? 8 26. Place of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Horna 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After 1 Matural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et tha time, data and place, end due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier onel 29b. Sign 29c. Licensa number 29d. Dete signed (Month, Dey, Year) and title of certifier 015236 ANGU ST w O. 20 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

11404 Old Georgetown Road Rockville, Maryland 20852

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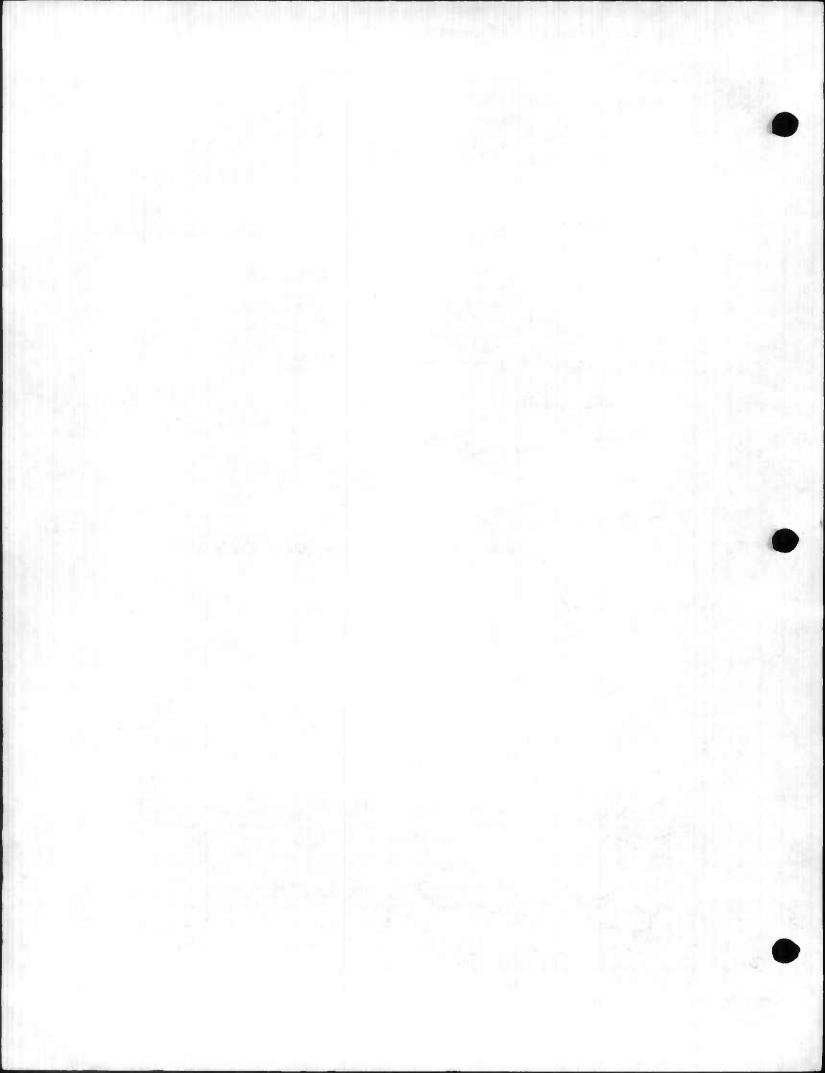
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31. Dete filed (Month, Day, Year)

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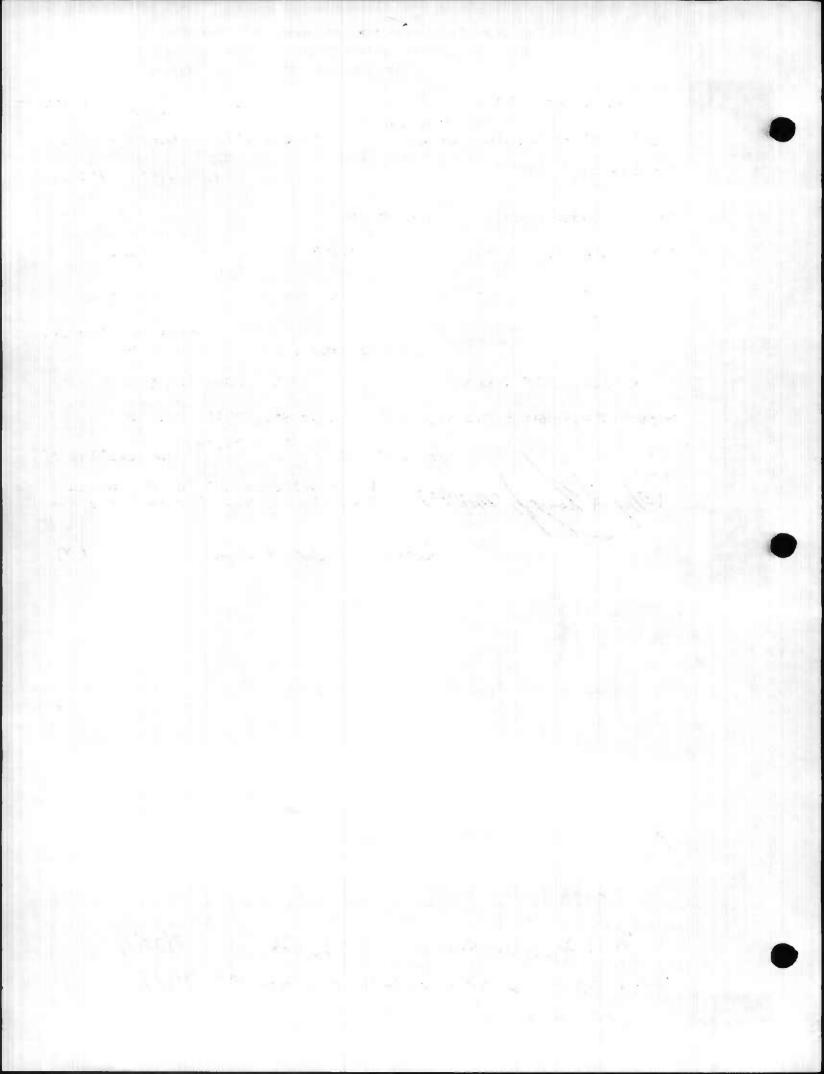


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Yae Physician CHESTER JAMES WATSON 10:07 PM 22, 1999 ath 4c. County of Deeth 4b. City, Town, or Location of Death /Medical 4a Facility Nema (If not institution, giva streat and number) Meredian-Examiner Queen Anne's Corsica Hills Nursing Center Centreville If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Devs Hours 1 1 2 □ F 83 Yrs. 214-32-0330 Director Jan. 20,1916 Virginia Usuel Rasidence of Decedant with the Meryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Md. Oueen Anne's Centreville Directo 10f. Zlp Coda 10e Street and Number 10g. Citizen of Whet Country? 21617 3014 Church Hill Road U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Evar in U,S. Armed Forcas? 1 Yes 2 No 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Cutalone Constr. el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Company Construction/Labor 8 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) . Pages 1 and 2 should be fit iment of Health and Mentel H. Lamt: If itsm 27 is marked oth Betty Anne Fitzgerald James Fitzgerald Watson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Raletionship (Type, Print) Betty A. Romanowski-Daughter 5758 Rodman St., Phil, Pa. 19143 July 27, 1999 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition 6 Buriel 2 Cremetion 3 Rem el from Stete permit. Page Depertment of Important: If any injury or page. Centreville, Md. Chesterfield Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Nama and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home 11093 408 S. Liberty St., Centreville, Md. times that caused the death. Do not enter the \emph{mode} of dying, such as cardiec or respiretory arrast, cause on each line. Approximete Intervel Between Onset end Death **Physician** Cerebrovascolor desire /Medicai Immedieta Causa (Fina diseese or condition resulting in deeth) Examiner Examiner the buriel-tran Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cousa (Diseasa or Injury that initiated evants resulting in daeth) Lest and Dua to (or as a consequence of) Physician/Medical Due to (or es e consequence of) 98 USe signed by the e Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveileble prior to completion of cause of daath? 24e. Wes en eutopsy Completed performed' pege 2 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director, Be 25. Was casa raferred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 5 Rasidance 8 Othar (Specify) 1 Yas 2 No this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Neturel Accident 5 Pending efter death. 1 Yes 2 No Investigation 6 Could not be datermined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicida To the Hospital within 24 hours e To the Funeral C 12 Cartifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end piece, and dua to the ceuse(s) and manner as stated.

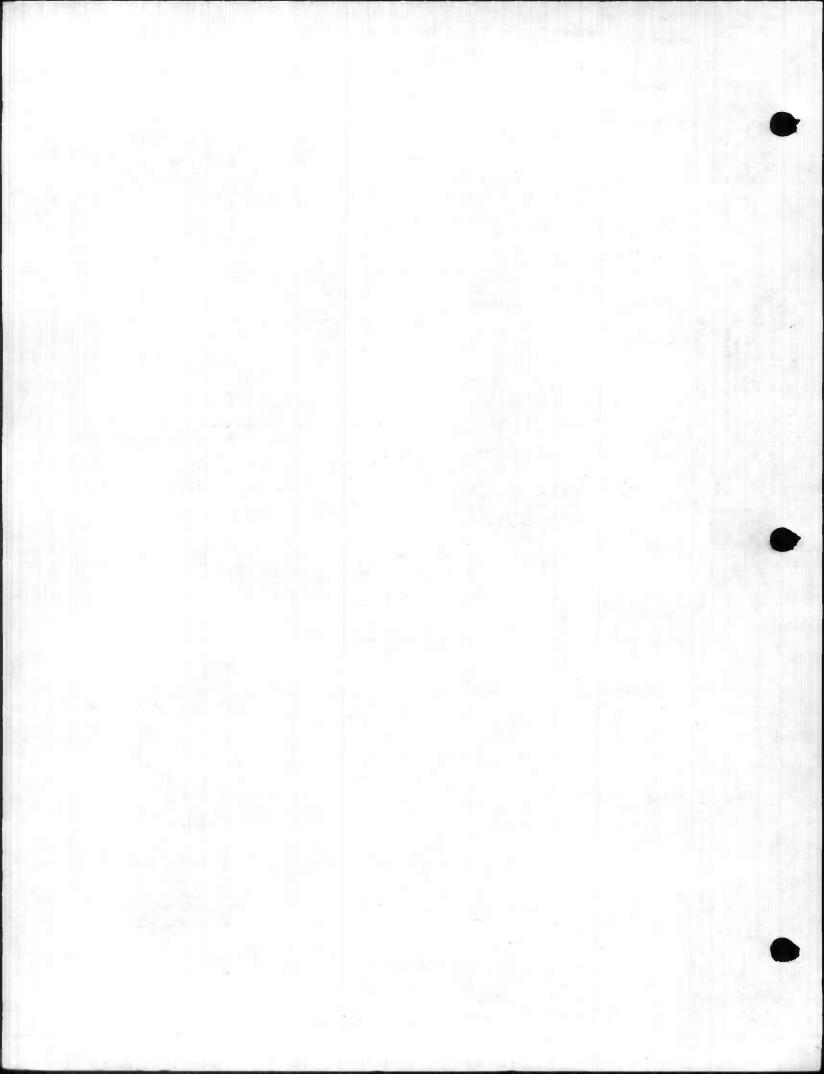
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, dete and place, and dua to the causa(s) end menner steted. edical 29a. Certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certiffe who completed cause of death (Itam 23e) (Type, Print) D. Dorch Drive Charles and 2/6/9 Some Day, Year) -108 31. Dete filed (Month, Day, 32. Registrer's Signeture

State Registrar

JUL 2 6 1999



	Decedent's Name (First, Middla, Last		Cei	tincate of	Death	2. Data of De	Reg. No.	- 6	3. Time of Death
ysician	The second secon	•				Month	Day	Year	
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aminer	Easton Memoria		al		Easton	JOANOT OF DOGS	Tall		
eral	5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days		8. Data of Bir (Month, De	th ty, Year)	9. Birthp	lace (Stata or Foreig
ctor	430-44-4394	□M 2√ F 7	3 Yrs.			July 28	3, 1926		insas
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Director	10e. Street and Number	ille 5	Stevensvi.	10f. Zip Code		T	10g. Citizen of 1	What Coun	try?
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doer must Funeral	11. Marital Status	12. Was Decedent Ev Armed Forcas?	var in U,S. 13.		Hispanic Origin? (Sp van, Mexican, Puerto	ecity Yas or No		e - Americ	
Examine by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yas 2 🔯 No If Yes, Give Year or Datas:		1 ☐ Yes 2 🖾 No	Specify:	rican, etc./		k, White, o	
Pag Pag	15. Decedent's Edu	cation	16a. Deced	dent's Usuel Occu	pation		16b. Kind of Bo		
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To to	John Julian Holt				Buena I	Robinson	n		
5	19e. Informant's Name/Ralationship (T)				t and Number or Run				
1	Evelyn B. Strawse 20a. Mathod of Disposition	r - Daught			n Drive, S	Date	ville, M		1666
5	1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo cematary, cren						
dan.	4 Donation 5 Other (Specify) 21 Signature of Enneral Service Licens		Oakland (ig.7,199	9 0akla	and,	MD
Suny I	21. Signatup of Fondaia Service Licens	11.0V	F		Helfenbeir ock Road,			ral H 1619	Home, P.A
	23a. Part1. Entar tha diseese, or compl shock, or haart failure. List only or	ications that thused to	na death. Do not ente	er the mode of dy	ng, such as cardiac	or respiratory a	rrest,	1019	Approximata Interval Between
ian	SHOOK, OF Haart landed. Cist Only Of							1	Onset and Death
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	rasulting in daath)		ua to (or as a conseq					1	
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SIC.	Part II. Other significant conditions cor	ntributing to death but	not resulting in the ur	nderlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of deat
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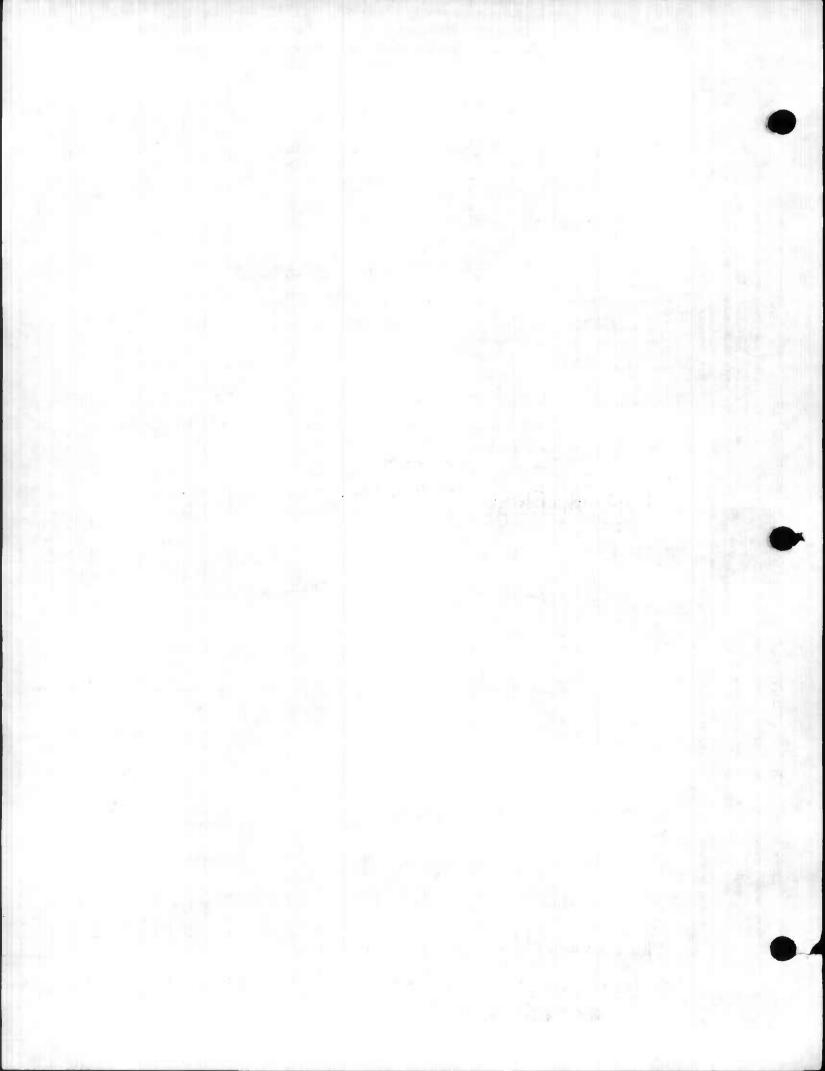
		HIGH	Amended Please Type or Print in Bla line 20C./SC State of Maryland /	Depa	rtment of	Health and N		_	ible.	6510
1	Physic	ian	7-23-99 WCHD & Line 26. 8/16/99 1. Decedent's Name (First, Middle, Last) Laurie Ann Wheel		rificate of	Death	2. Date of D Month	Reg. No. eath Day	Yaar	3. Time of Death
	/Medi Examii	cat	4a. Facility Name (If not institution, give street and number)	- W		4b. City, Town, or L		th 4c. Count	99 y of Deeth	12:30PM
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Maryland 21215-0020	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) 4	(Give k life. D		pation a during most of work ad) CO-Ord		16b. Kind of E		
and	nd 2 should be filed within the and Mental Hygiene. 27 is marked other than r traumatic event, the Mental Hygiene.	o Be C	17. Father's Name (First, Middle, Last) RAYMOND WHE			18. Mother's Nem	e (First, Middle	e, Melden Sume		
lary	end 2 should setth and Men n 27 ie marke er traumatic	To	Maymona Miclici		Address (Stree	Mar t end Number or Rui	ie Dai		, Stete, Zi	p Code)
	O O E E		20a. Method of Disposition 20b. Place	of Dispos	tion (Name of	Avenue,	Dete	20c. Location	- City or T	own, State
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Bal	permit. Departingoru Importi		21. Sign, let of Funaral Sarvice Licensee M-0849 Paul T T D on Stamp 1 23a. Part 1. Enter the distance of complications that cabled the death. Do shock, or heart failure. List only one cause on each line.	1 I r	05 Mery	ationwid win Aven	ue,	Clevela	nd, O	h. 44113 Approximate Interval Between
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	the Hosp hin 24 ho the Fune npletely f	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge of the basis of examination a end manner stated.	ge, daath o ind/or inve	stigetlon, in my	opinion, daath occur	and dua to the red at the time	, deta and piece	, and dua t	o tha cause(s)
	V vii		29b. Signature and Bill of Certifier 30. Name and eddrass of person who completed cause of daath (Item 23a	\ (Ture P	29c. Licen	6326	(Md)	7/2	E Month,	Q (Year)
	Sta	to	Name and educases of person who completed cause of data (frem 25a) Name and educases of person who completed cause of data (frem 25a) Name and educases of person who completed cause of data (frem 25a) 13. Date filed (Month, Dey, Year) 32. Registrer's Signature	601.8	etown	Blvd, E	(dest	ery. Mo	121	784
	Registr		AUG 1 6 1999	G.	Spars	2				

Marie - A stable

State of Maryland / Department of Health and Mental Hygiene o Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dev **Physician** 4. 1999 4c. County of Death CHARLES ELWOOD AUGUST 1:15 p.m. WILLIAMS, SR. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (if not institution, give street and number) Examiner Frederick Memorial Hospital Frederick If Under 1 Year Birthplace (State or Foreign Country) 7. Age (in yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 10 M 2□ F Months Yrs. **Director** 224-52-5081 Usuel Residence of Deceden 66 Apr. 17, 1933 Virginia 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Example; must be notified at 1⊠Yas 2□No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s and Injury or other treumstic event, the Medical Examples mass and page. Funeral 21702 650-F Heather Ridge Dr 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 NYes 2 No
H Yes, Give
Year or Detes: 1953-60 1 ☐ Never Merried 2 ☐ Merried Specify: White altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 typesetter newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Walter Moore Williams, Sr 19e. Informant's Neme/Reletionship (Type, Print) Sarah Florence Robinson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 East Patrick Street, Frederick, MD 21701 Betty Hann-sister-in-law 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 8/7/99 Mt. Olivet Cemetery Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signeture of Faneral Service Licensee MO0999 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause by each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) -Weated EMPHYSEMA Examiner Due to (or es a consequence of): CORONALY ARTERY 12 YRS Physician/Medical Examiner DISCASE ettending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Box 68760, Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifica Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death edical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural efter deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier D47611 AU6057 4, 1999 Warand 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 TANEY AVE # 204 FREDERICK MD 21702 NEIL WARANDEKAR MD 32. Registra s Signeture 31. Date filed (Month, Day, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Dey Year				olato ol many	Cei	tificate of	f Death	R	ng. No.	25512
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE 1. S. HITM, JR. M.D. VICE-PREN MED. AFFRIKE FREDERICK MD, 21701	o uo	nding Phath. r: After the funeral	1 Netural 5 ☐ Pending		ar) 28b. Time of Injury			28d. Describe ho	ow injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE 1. S. HITM, JR. M.D. VICE-PREN MED. AFFRIKE FREDERICK MD, 21701	DIVIS	al or Atte s after de al Directo ed in by th	determine	289. Piece of injury -	At homa, farm, str pecify)	eet, factory, offic	00			r Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE 1. C. H. TH., J.R. M.D. VICE-PRES MED. AFFRIKE FREDERICK MD, 21701		n 24 hour n 24 hour ne Funer pletely fill edical ((Check only 2 Medical Exa	miner: On the basis of exa						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE 1. S. HITM, JR. M.D. VICE-PREN MED. AFFRIKE FREDERICK MD, 21701		withi To th comp	29b. Signature and title of certifier	^	VPMA	29c. Lice	nse number	2	9d. Date signed (M	fonth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICE MEMORIAL HORIZOLE FREDERICE MED, 21701			10	-01 ()	M.D	DI	0587		8/10/	99
			30. Name and address of person who	completed cause of death	(Item 23a) (Type.		Eps	DERICE L	EHORIAL	Hospital
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		State				4	1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Elaine Frances WORTHINGTON August 10, 1999 10:45 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day Year) 1910 Maryland 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□M 2√2F 89 214-10-4921 Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick XYes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 527 Wilson Place 21702 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: Race - American Indien, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after their of Health and Mental Hybjane.

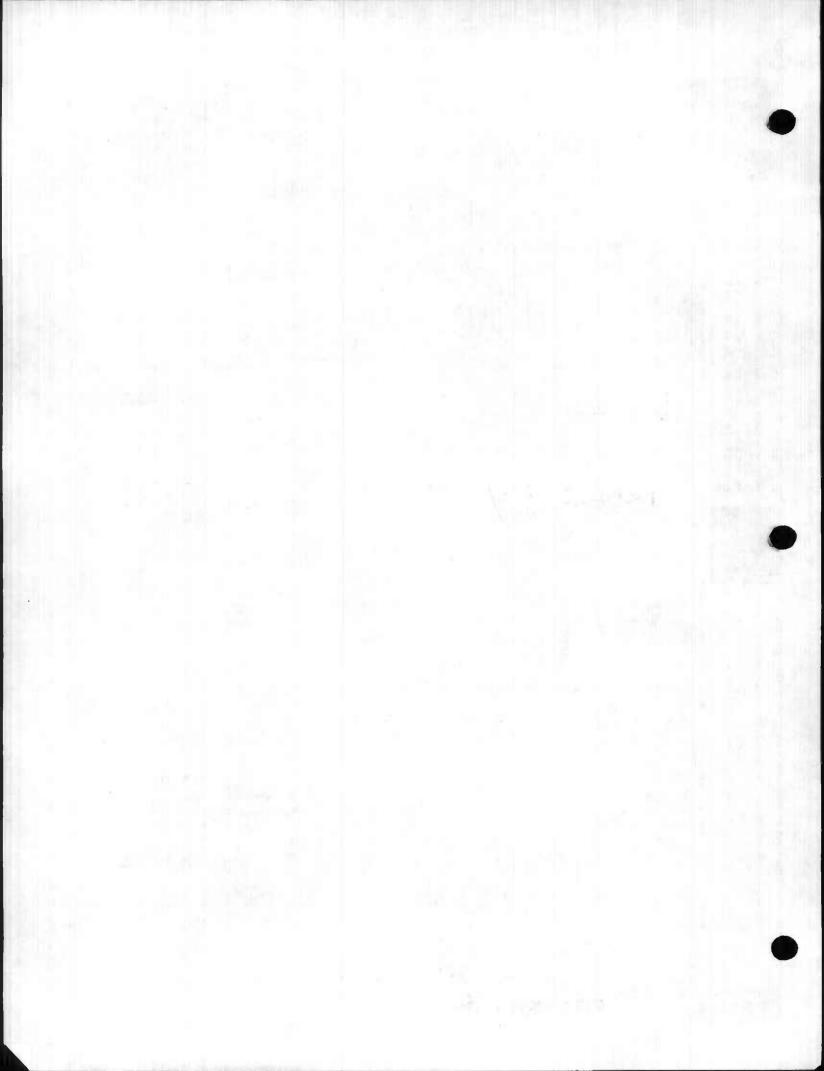
ant if them 27 is marked other than "natural, or its with or other transmitted over the Mental Saurine any or other transmitte event, the Medical Equation 1 Never Merried 2 Married 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Samue1 Walter WORTHINGTON Hornora 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mr. Lilburn S. Waters, nephew 8421 Walter Martz Rd., Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlai 2 □ Cremation 3 □ Removel from Stete Mount Olivet Cemetery, August 12, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part 1. Enter the disease, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Heart Failure 24 hrs Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending chusician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760 the Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 Probably 4 Unknown Collagen vaseulen Distas Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 10, 1999 D09689 arra 30. Name and address of person who completed cause of death (New 23a) (Type, Print)

Dr. Austin Pearre, Jr., 300 West Ninth Street, Frederick, Maryland 21701

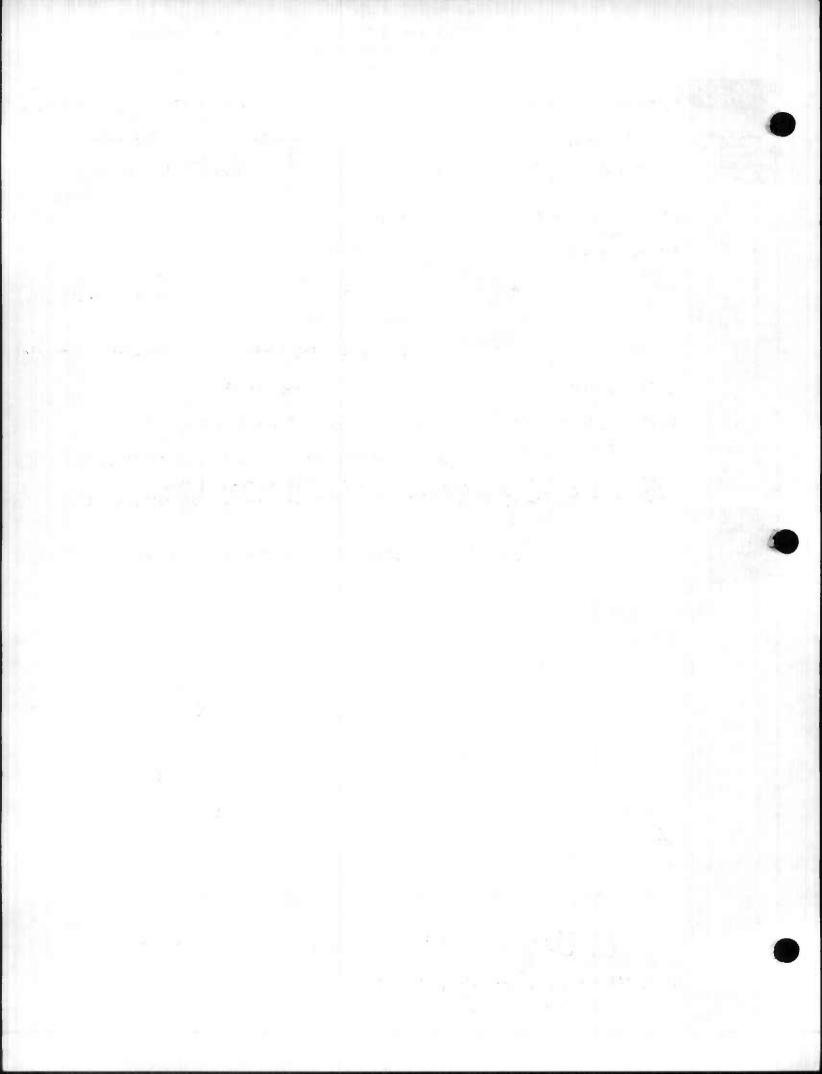
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State of Maryland / Department of Health and Mental Hygiene

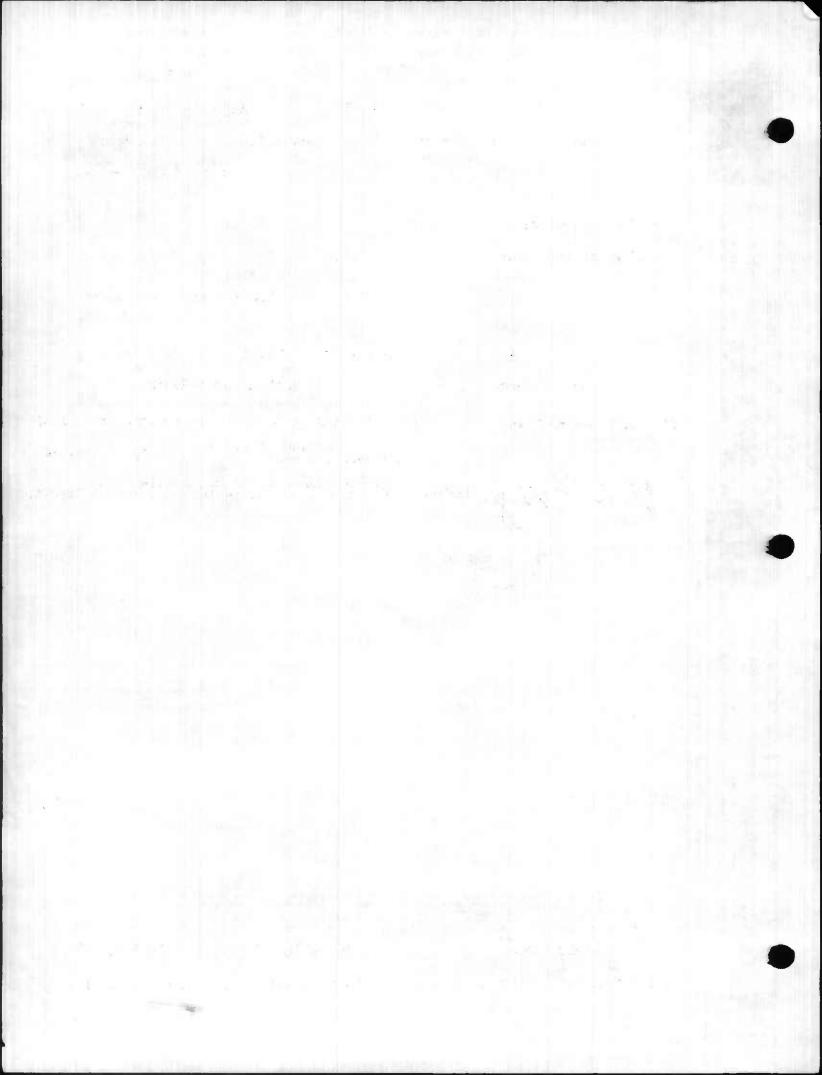
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	/Medic		4a. Fecility Name (If not institution		ad			th City Town or L	August			3:00 a.m.
<i>)</i>	xamir	ier		give street end numb	er)		1	4b. City, Town, or Lo		4c. County		
_			109 4th Avenue 5. Sociel Security Number	6. Sex 7.	Age (In yrs. lest	birthday) # Under 1	Voor	Brunswic			ederio	
Dir	neral ector		186-38-7535 Usual Residence of Decedent	1 □XM 2 □ F	49		Days	Hours Min.	8. Date of Birth (Month, Day June 2	1950	9. Birthpi Count Mich	aca (Stete or Foreign try) 1gan
Jand	W 11		10e. Stete 10b. County		10c. City, To	own or Location					10	Dd. Inside City Limits
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Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene.	naminer m	by Funeral Director	11. Maritai Stetus 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decade Armed Force at 1 XYes 2 If Yes, Give Year or Date	es? □ No	13. Was Decede If Yes, specif	,	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e y:	
2 hou	Cal E	ted	15. Decedent	s Education	16	6a. Decedent's Usuel	Occup	ation		16b. Kind of B	usiness/Ind	ustry
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Maryland od 2 should be file tith end Mental Hy	New New	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Name	First, Middle,	Maiden Suman	ne)	
Via ould I	atic	10	Ozelle S. White					Nancy Fr	rank			
Aar 2 sh	Tarmar Language		19a. Informant's Name/Relationsh	ip (Type, Print)	1	9b. Mailing Address (Street	end Number or Run	al Route Number	r, City or Town,	State, Zip	Code)
end lealth	her ti		Shirley S. Whit	e, Wife		109 4th Av	enu	ie, Brunsv				
Baltimore,	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Removal from Sta	20b. Placa came	of Disposition (Name stery, crematory or oth	er plea	ca)	Date	20c. Location -	City or Tov	vn, State
Pe He	L A		4 ☐ Donation 5 ☐ Other (Sp			rstown Cre	ema t	cory	3/13	Hagers	town,	MD
Sal	any in		21. Signature of Fundral Servica L	icansee	11/11	22. Name end	Addre	ss of Facility	- I coon	Llama		
40.	= ei Ol		Barbara A. W	Tliams, Ov	vner	100 Pe	ter	sville Ro	oad. Bru	nome	MD 2	21716
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caus	sed the death. D	o not enter the mode	of dyin	g, such as cardiac	or respiretory arr	est,		Approximate Interval Between
Phys												Onset and Death
⊸ /Me∉ Exan	dical		Immediate Cause (Finel disease or condition	Sou	mous	CEU C	TH	ZCINONV	FAR	LUNC		3 MOS.
LAGII			resulting in death)	0.		a consequenca of):						
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bg/bu/ ifficate be executed	es the buriel-transit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or as	e consequenca of):						
66 / 60,	burie	E I	Cause (Disease of Injury	C								
cete	the	9	thet initieted events resulting in death) Last		Due to (or es	e consequence of):						
		~		d								
The law requires that the death cer	should be deteched for use	Physician/									İ	
et the death cer	ped	ysic	Part II. Other significant condittor	s contributing to death	n but not resulting	g in the underlying cau	use giv	en in Part I.	23b. Did to	bacco use co	ntribute to	the cause of deeth?
The tr	detec								10(Y	es 2 No	3 Prob	ably 4 Unknow
dS,	200	d by							0.4		24b Was	en automou finalia an
	pods	Completed							24a. Wes e perfor	med?	ava	re autopsy findings ilable prior to apletion of cause
Kecords,	200	du l										leath?
VICION: The	director, pege								1 🗆 Y	es 2 XNo	1 🗆	Yes 2 No
Clan	ector	Be	25. Was case referred to medical examiner?	Hospital				26. Place of Death	(Check only on	re)		
OI VITA Physician:	aldir	70	1 Yes 2 No	Hospital:		Outpatient 3 DOA	1	4 LI Nursing Ho)
DIVISION Of VITAL for Attending Physician: T after death. Director Attentities cardition		on	27. Manner of Death 1 DNatural 5 ☐ Pending		Da <i>y Year)</i> 28b		c. Injun Worl		28d. Describe ho	ow injury occur	red	
Sign	the	cat	2 Accident Investigation Accident Accide	t ho		М		Yes 2 □ No				
or Al	in by	Certification:	4 ☐ HomicIde determin	ed 286. Placa of	Injury - At home, etc. (Specify)	farm, street, factory,	office	1	28f. Location (St City or Town		er or Rural	Route Number,
ie de la	pejji		202 0-44: 4516	-		. 10						
DIVISION To the Hospital or Attending: within 24 hours after death. To the Funeral Director, After	completely filled	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be- camtner: On the basis	or examination i	ge, death occurred at and/or investigation, in	the tim	ne, date and placa, i pinlon, death occurr	and due to the co ed at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
other ithin	Jdwc	Me	29b. Signature and title of certifier	end manner	318180.	290	License	e number	2	9d. Date signe	d (Month D	lav Year)
H F H	. 8	70		101	MN				-			my, 1 0ml/
	Ì	-	Wl	mari	117		667	כ		8/10/9	19	
			30. Name end address of person w	11								
			Wayne Allgaier, 31. Date filed (Month, Dey. Year)	MD, Bruns	SWICK, M strang Signature							
B	Stat egistra		AUG	2 1999 b	Signature	~ B		carle				
DAMM 16 6			,,,,,	- 2 .000		10.	19	carly				



State of Maryland / Department of Health and Mental Hygiene

Dhusisian	1. Decedent's Neme (First, Middle, La			Certificate of		2. Date of De		Year	3. Time of Death
Physician /Medical	Ollie Martha N	Vilt				JULY	17, 1999	1000	0840
Examiner	4a Facility Neme (If not institution, gi Sacred Heart Ho:				4b. City, Town, o Cumberla	r Location of Deat and	4c. County of		
Funeral Director		Sex 7. Age (In 1	yrs. last birth Yı	Months Dave			th iy, Year)		e (Stete or Foreigi)
death with the Maryland ms 23s or 23s-! show r.must be notified at neral Director	10a. State 10b. County Md Allega		:. City, Town					10d	. Inside City Limits
with the Marylan a or 28e-f show Lbe notified at I Director	10e. Street and Number		Hebeca	10f. Zip Code			10g. Citizen of W	het Country	
ther death will refer them 23a other must be diner must be burneral C	Rt. 1 Kolberg	Hill 12. Was Decedent Ever	in 11 C	2156		Canaity Van or No	United	Stat	
urs attac Mr. or the Examine Dy Fur	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes:	#1 0,5.	13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No		rto Rican, etc.)	Bleck Specify:	White, etc.	
n 72 h "natu ledical	15. Decedent's E (Specify only highest gr	ade completed)	16a. D	decedent's Usual Occu Give kind of work done ife. DO NOT use retin	pation during most of w	orking	16b. Kind of Bus	iness/Indus	stry
lised within 72 ho Hygiens. ther than "naturn ent, the Medical.] s Completed	Elementery/Secondary (0-12) Unknown	College (1-4or 5+)		memaker			Hom	e	
Be edge	17. Father's Neme (First, Middle, Last					ame (First, Middle	, Maiden Sumeme)	
d Men marks marks To	Frank Somerville 19a. Informent's Neme/Reletionship		104 -	Meiling Address (Stree		ie Imes	or Cib. or Town	tata 7:- C	nda)
and 2 shr saith and n 27 is m or traum	Pauline Russell/I	7.1		5015 Parad					ode/
Pages 1 a tent of Hea mt if Item iny or othe	20e. Method of Disposition 1 Surial 2 Cremetion 3 [4 Donetion 5 Other (Speci	20	Ob. Place of Cometery,	Disposition (Name of crematory or other places Cemetery	ace)	Date	20c. Location - 0	City or Town	
permit. Departm Importa any inju	21. Signeture of Funerel Service-Lice		l	22. Name and Addr Boal Fune	ess of Facility	111	Church Sernport,	t.	21562
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		to (or as a co	nsequence of):					1 d zy
death certificate be executed e attending physician and bd for use as the burial-transit	Sequentielly list conditions, if ery, leading to immediate cause. Enter Underfying Cause (Diseese or Injury that initieted events resulting in death) Last	c		nsequence of):					
thy ach	Pert II. Other significant conditions of	contributing to death but not		he underlying cause g	iven in Part I.		tobacco use con	tributs to ti	/
s been sign s been sign 2 should be pleted by	Distretes un	ellefis					an autopsy ormed?	availe	autopsy tinding able prior to eletion of cause ath?
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Physician: The this certificate ral director, pag.: To Be Co.:	25. Was case referred to medical examiner? 1 Yes 2 No	Hospitel:	•□55:÷		ther	sath (Check only		10	
Attending Physic in death. ector: After this co by the funeral direction: To	27. Menner of Beeth 1 Preturel 5 Pending 2 Accident Investigation	28a. Dete of injury (Month, Day Yea	28b. Tin	ne of 28c. Injury	4 LI Nursing	Home 5 Resi	how injury occurre		
- 2 E C T	3 Suicide 6 Could not be determined	e One Place of Injury	At home, ferm			28f. Location (City or To	Street and Numbe wn, State)	r or Rural F	Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29e. Certifier (Check only one) 1 Certifying Property Control on 1 Certifying Property Control on 1 Certifying Property Certifying Certifyin	ysician: To the best of my niner: On the basis of exan end menner stated.	knowledge, on minetion and/o	leath occurred at the tor investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred et the time,	cause(s) end mar date end place, a	ner as stet nd due to th	ed. ne cause(s)
To the To the comp	29b. Signature and title of certifier ;			29c. Licen D 5	2056		29d. Date signed	(Month, Da	
2		completed cause of death		ype, Print)	u nose	Cumis	rland	mp	2150
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's S		6 6					

ian	1. Decedent's Name (First, Middle,	Last)		Certifica	ile or i	Douth	2. Dete of D	Reg. No	6.0	3. Tima of Death
cal		Rene	D.	Zan	nbran		Month August	4, 1999	Yeer	5:30 AM
er	4a Fecility Neme (If not institution, g					b. City, Town, or				
	Shady Grove		-	William	ler 1 Yeer	Rockvil			gomery	
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	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town	or Locetion					100	d. Inside City Limit
5	,								1.00	1 ☐ Yes 2 ☒ N
Director	Maryland Montgo	mery	Darnest		Zip Code			10g. Citizen of V	What Countr	v?
ŝ	14900 Plainfiel	ld Iana			0874			United		
1	11. Meritel Stetus	12. Wes Decedent I	Ever in U.S.			lispenic Origin? (S	specify Yes or N		e - Americe	
	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?			2 □ No	lispenic Origin? (Sen, Mexican, Puer Specify: Sout		- 1114	k, White, et Whit	
	15. Decedent's	Educetion	16e. C	Decedent's Us	suel Occup	etion		16b. Kind of Bu	ısiness/indu	stry
1	(Specify only highest (Etementery/Secondary (0-12)	grede completed) College (1-4or 5		Give kind of v life. DO NOT	work done use retired	during most of wo	rking			
-	Comomony/Secondary (0-12)	4		craft	Broke	r & Pilo	t	Self E	Employ	ed
	17. Father's Neme (First, Middle, La	*						, Maiden Sumem	(e)	
	Luis	Zambrana				Maria	Luisa D	elgado		
	19e. Informent's Neme/Relationship	(Type, Print)	19b.	Melling Addre	ss (Street	and Number or R	ural Route Num	ber, City or Town,	State, Zip C	Code)
	Elsa B. Zambrana	a/Wife	14	900 P1	ainfi	eld Lane	, Darne	stown, M	lary1a	nd 20874
	20e. Method of Disposition	5-	20b. Place of I	Disposition (A	leme of	(e) August	6 Date 1999	20c. Location -	City or Tow	m, State
	1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spe		Gate o	f Heav	en Ce	metery	0, 1333	Silver Sp	ring, l	Maryland
	21. Signature of Funeral Service Lin	//	M00846	Robert 300 Wes	end Addre A. Pu st Mon	ss of Fecility mprey Fune tgomery Av	eral Home/ enue, Ro	Rockville, kville, M	Inc.	1 20850-280
	23a. Pari1. Enter the disease, or co shock, or heart fellure. List on Immediate Cause (Finet disease or condition resulting in death)	a. Pneumo								Approximete ntervel Between Onset and Deeth Days
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The state of the s	I that initiated events	d	ut not resulting In	the underlying	g ceuse giv	ren In Pert i.	23b. Dio	I tobacco use co	ntribute to	the cause of deat
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Brown 9:58 AV ichard August 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth Baltimore Rehabilitation + Extended Gove Baltimore If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 369-16-7211 06/24/1918 Michigan Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2000 Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 130 Springside Drive 21093 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. tXXYes 2 □ No If Yes, Give Yeer or Detes: WW II 1 Never Merried My Merried 1 ☐ Yes 2XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coilega (1-4or 5+) 12 Bakery Engineer Manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Leo Brown Marie Rose Amberg 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Mary Ann Brown/wife 130 Springside Drive Timonium, Maryland 21093 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial X ☑ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Serv. Corp. 08/20/1999 Towson, Maryland 21. Signeture of Funeral Service Licenses tenneral D. Coster 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or hear failure. List only one causa on each line. Approximata Interval Between Onset and Deeth Dementia Immediate Cause (Finel Multi infarction 2 years disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Dua to (or es a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveileble prior to completion of cause of daeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Dey Year) 27. Menner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide

pug physician 2 Division of Vital Records, P.O. Deen certificate 를

Physician/Medical þ Completed 88 2 Certification:

4 Homicida

(Check only

29a. Certifier

Physician

/Medical

Examiner

Director

Funeral

þ

Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, tra Medical Externiner must be notified at

Department of important: If it any injury or o

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. nt: If them 27 is marked other than "natural", or thems 23s

Baltimore, Maryland 21215-0020

with the Maryland

ed by the a signed by t after death Director: To the Hospital of within 24 hours a To the Funeral D completely filled

Registra

Medical

29b. Signeture and title of certifies

29c. License number

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

D0032548 ne end addrage of person who complated cause of death (Itam 23e) (Type, Print) Baltimore VA Medical Center Rky L COLVIN MD (ON. Greene St. Baltimore MD ION. Greene

1 Certifying Physician: To the best of my knowledga, daeth occurred et the tima, deta and pieca, end due to the causa(s) and menner as stated.

2 Medical Examinar: On the bests of axamination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner steted.

32. Registrar's Signeture

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme /First Middle (ast) 2. Date of Deeth 3. Time of Death Month Day BROWN 6:35 22 4b. City, Town, or Location of Death 4c. County of Deat 4a Facility Neme (If not institution, give street and number) BALTIMORE SECOURS 5. Sociel Security Number 6 Sex 8. 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) 224-38-0765 1MM 2DF Days Hours Usuel Residence of Decedent 10h Count Town or Location 10d. Inside City Limits 1 PYes 2 No 10f. Zip Code 10g., Citizen of Whet Country? Wes Decedent Ever Armed Forces? 1 1 Yes 2 No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Meritel Stetus Black, White, 1 Never Married 2 Married 1□ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Hodian 8. Mother's Name (First, Middle, Maiden (First, Middle, Last) rment's Name/Relationship (Type, Print) 20b. Piece of Disposition cometery, cremeter 20c. Location - City of Town Date 27 20a. Method of Disposition 1 Burlei 2 Cometion 3 Removel from State 4 Donation 5 Other (Specify) 21. Signature of Puneral Service Licens for complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, Linvonly one ceuse on each lina. Approximate Intervel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) STROKE COOCULAPATHY TRAVASCULAR Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

p

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumetic event, the Medical Examinations to notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s any injury or other traumatic event.

altimore, Maryland 21215-0020

with the Maryland

Examiner attending physician and for use as the burial-transit page 2 s

signed by the a d be detached f certificate funeral director, After this

or Attending Physician: within 24 hours after death. To the Funeral Director: Af filled in by

1 Yes 2 No

5 Pending

Investigation

6 Could not be determined

27, Menner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signeture and title of certifier

Division of Vital Records, P.O. Box 68760, **Physician/Medical** þ Completed Certification: To

To the Hospital Medical

State Registrar

D 0030355

SECOURS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) end mannar es stated.

28c. injury et Work?

1 Yes

3□ DOA

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print),

BON

2 ER/Outpatient

28e. Plece of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

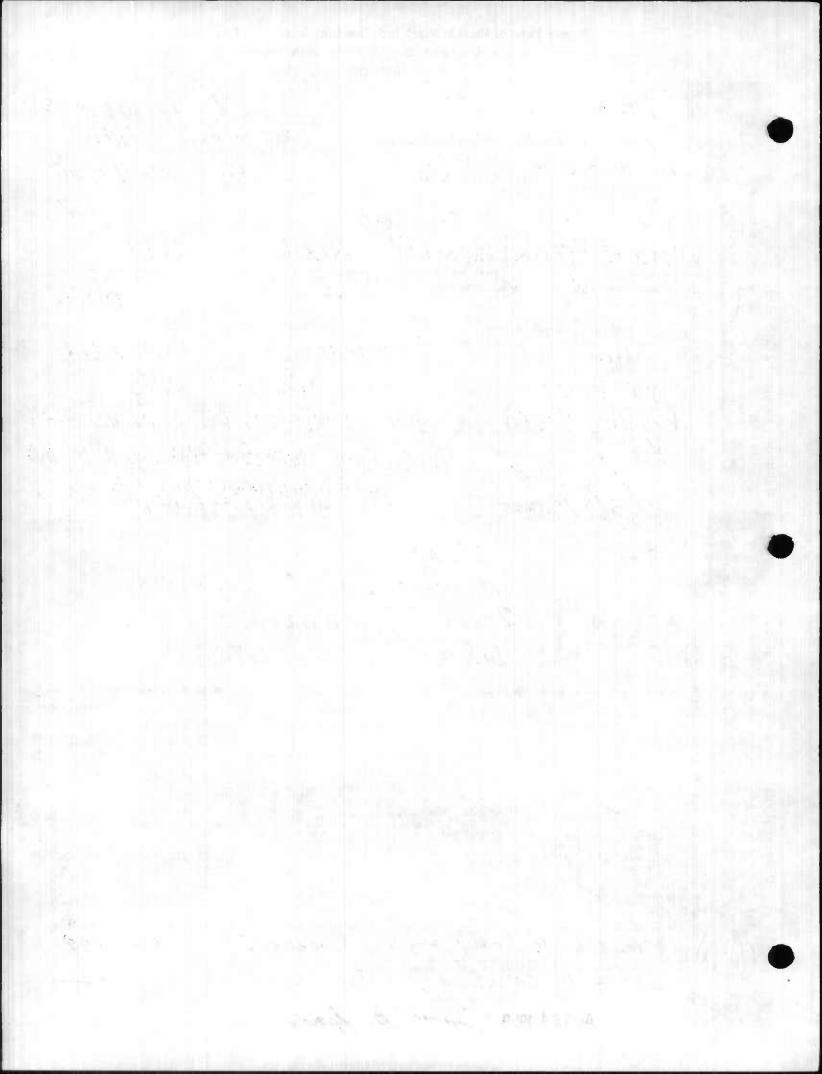
28b. Time of

32. Registrar's Signature

1 inpatient

28e. Dete of injury (Month, Dey Year)

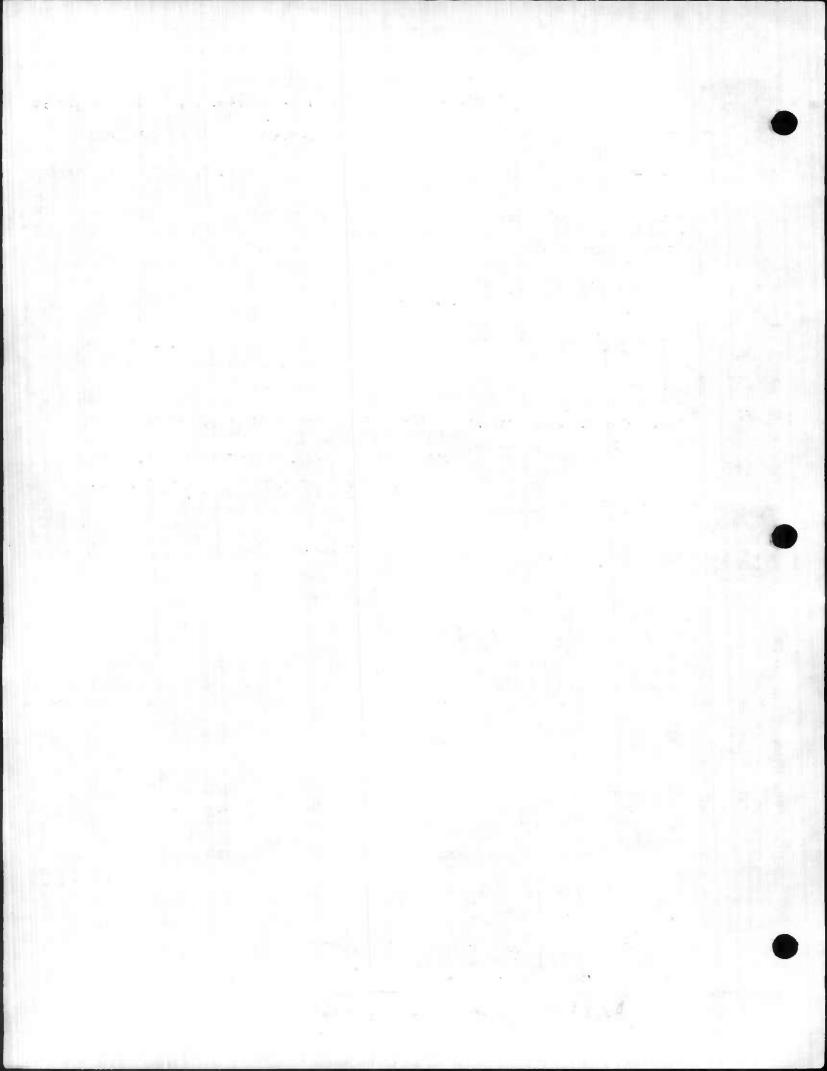
31. Dete filed (Month, Day, Yeer) AUG 2 4 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 26519

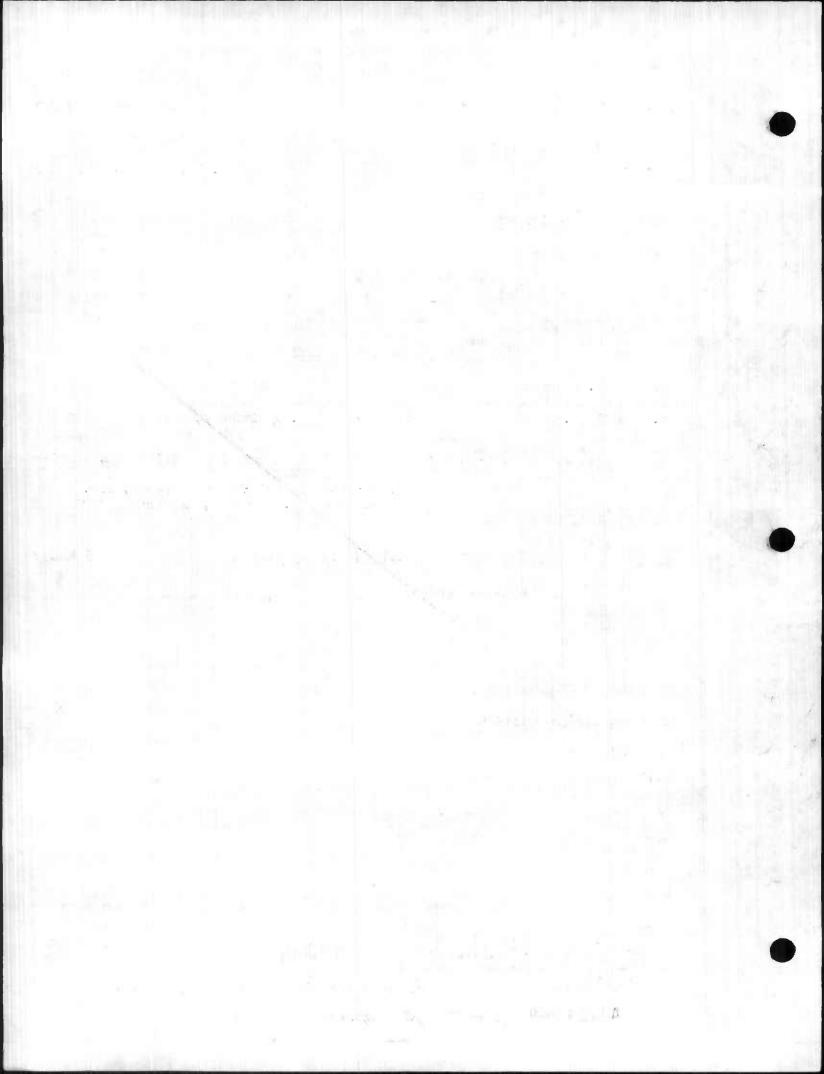
				Ce	rtificat	e of	Death			Reg. No.	w 1-	.0015	
Physician	1. Decedent's Name (First, Midd							1	2. Date of De	eath Day	Year	3. Time of Dea	
/Medical		2	Sterlin	9	Bower, Sr.					Aug. 20, 1999 11:50			
Examiner	4e Facility Name (II not instituted 7415 Belmont		umber)			1	b. City, To Dund		ation of Deat		ty of Death		
Funeral Director	5. Social Security Number	6. Sex 1 2 M 2 □ F						Date of Birth (Month, Day, Year) 19. Birthplace (Stete Country) 19. 7, 1921 Pennsylva:					
	Usual Residence of Decedent									12 01111	Dy I vaniza		
72 hours enter death with the Maryland natural, or Nems 23a or 28a-f ahow dical Examinar must be notified at eted by Funeral Director	10a. State 10b. County	, Baltimore		City, Town or L	ocation		Du	nda1)	ς		1	10d. Inside City Lir 1 ☐ Yas 2	
with the Ma ta or 28a-fa to notified		Avenue			10f. Zip	Code		212	24	10g. Citizen of	What Cour	ntry?	
era era	11. Marital Status		cedent Ever in	U.S. 13.	Was Dece	dent of H	ispanic Ori		cify Yes or No	- 14. Ra	ce - Americ	cen Indian.	
at, or Hems 23s or 28s-f show Examiner must be notified at by Funeral Director	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorce	Armed I	Forces? 2 ☐ No Give Dates: W.		If Yes, spec	cify Cuba	Specify:	n, Puerto F	lican, etc.)	Speci			
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Hygiene. ther than mt. the M	Elementary/Secondary (0-12) 12 years	College	(1-4or 5+)	M	aster	Ser	geant			U.S.	Air F	orce	
I de E		Last)					18. Mothe	er's Name	(First, Middle	, Maiden Suma	me)		
20 m	Sherman Bower						Cora	Hess	5				
	19a, Informant's Name/Relation	ship (Type, Print)		19b. Mail	ing Addrass	(Street				er, City or Town	n, State, Zij	o Code)	
0 0 0	Mrs Polon C	Downer / W	7: 50)	7415	Relm	ont	Poad	Ralt:	imoro	Marrila	nd 21	222	
if Health Hem 27 I other tra	Mrs. Helen S. Bower (Wife) 7415 Belmont Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Ama of Company Company) (Ama of Company												
rtment or rtant: If	1 Burial 2 Dicremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other place) Hilltop Service Corp. 8/23/1999 Towson, Ma												
	21. Signature of Funaral Service		H		Servi 2. Name an				1/ 1999 Towson, Maryland				
Impo Impo In Ir	Johnny L.	Gues		D	uda-R	uck	Funer	al Ho	ome of	Dundal e, Mary	k, In land	21222	
	23a, Parf 1/ Enfer the disease, o shock, or heart failure. Lis	r complications that	caused the de	eath. Do not en	itar tha mod	a of dyin	g, such as	cardiac or	respiratory a	rrest,	1	Approximate Interval Batween	
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	resulting in death) Last			(0. 00 0 0 0 0	400						i		
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has mp									-		Of	death?	
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director,	25. Was casa refarred to medice examiner?					l mu		of Death	(Check only	one)			
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	27. Mannar of Death 1 Natural 5 ☐ Pendi	28a. Date	of Injury oth, Day Year)	28b. Tima o Injury		8c. Injun Wor		4	8d. Describe	how injury occu	irred		
tor: A the fu	2 Accident invest	gation			М	1 🗆	Yes 2	No					
is effected. al Director: After the in by the funering Certification:	3 Suicide 6 Could 4 Hornicide detarr	nined 288. Plac	e of Injury - Atding, atc. (Spe	homa, farm, st	reet, factory	, office		2	8f. Location (City or To		nber or Run	al Route Number,	
ral Dir													
within 24 hours effer death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	e best of my k basis of exami nner stated.	nowledge, deal nation and/or in	th occurred ivestigation,	at tha tin , In my o	ne, data an pinion, daa	d place, a th occurre	nd due to tha d at tha tima,	cause(s) and n data and place	nanner as s , and dua t	stated. to the cause(s)	
omp omb	29b. Signature and title of-pertific	r	0		290	. Licens	a number			29d. Date sign	ed (Month,	Day, Year)	
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6	30. Name and address of person	who completed/cat	of death (It	em 23a) (Type	Print)		Acce	RIT	0.00	0.1	2/22	U	
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State	31. Date filed (Month, Day, Year,	1000 32.	Begistrar's Sig	natore 4	1	2.1	,						
Registrar	AUULA	וטטט .	- Mary	1.	1000	us							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Data of Death 3. Tima of Death Month **Physician** Blevins 1423 Arville Odell August 1999 21 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (II not institution, giva street and number) 4c. County of Death Examiner Baltimore Baltimore Johns Hoplans Bayview Emergency Department If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 16,1925 5. Social Security Number 9. Birthplace (Stata or Foreign Country) West Virginia 7. Aga (In yrs. last birthday) 6. Sax **Funeral** Months Days Hours 1₩ 2□ F 216-16-8297 74 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1 Yes 213No Directo Edgemere Baltimore Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 21219 United States 7435 Blevins Avenue Berrie 23a Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yes, Giva Yaar or Datas: 1945-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, atc. after 1 Navar Married 2 ☐ Married 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: à White 72 hours 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) Collega (1-4or 5+) Not Known Steel Industry Quality Control Department of Health and Mental Hygin important: If them 27 is marked other any injury or other trauments. Saltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Bessie Ashley Timothy T. Blevins Son 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mr. Orville O. Blevins 1334 Spring Ave. Baltimore, Maryland 21237 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Oak Lawn Mausoleum 8/25/1999 4 □ Donation 5 ₺ Other (Specify) Entombment Baltimore, Maryland 21. Signature of Funaral Sarvice Licensea 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Johnny I Sido 7922 Wise Ave. Dundalk, Maryland 23e. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervet Between Onset and Death **Physician** /Medical Immediata Cause (Final 5 hours a massive intracerebral disaasa or condition rasulting in daath) hemogrhage Examiner Due to (or es a consequence of): Examiner hypertension physician and s the burlal-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 980 ŏ 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown coronary artery disease by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hypercholestrolemia has esophagitis, duodenitis 2 340 1 Yes 2 No certificata Be 25. Was casa refarred to medical axeminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this After thi 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera Certification: 28b. Tima of Natural 5 Pending Invastigation 1 Yes 2 No 2 Accidant 6 Could not be datarminad 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida Descritifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a, Cartifian (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier August 21 OX 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Johns Hopkins Buyin Energency Reportment Hirshon Jon Mark AUG 2 4 31. Data filed (Month, 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Dorothy L. Barnes August 20, 1999 12:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Inn Convolescent Center Baltimore N/A 8. Date of Birth (Month, Day, Year) Dec. 2, 1913 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign Days 1□ M 20 F Months Hours 85 Maryland 217-26-1937 **Usuet Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 3122 Chesterfield Avenue 21213 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 2 No if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 12th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Sindell Harrison Boyd 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Edward L. Boyd (Nephew) 209 Ridgefield Road, Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Druid Ridge 8/23/99 Baltimore, Maryland 22. Name and Address of Facility Schumuner Funeral Home Inc. 21. Signature of Funeral Service Licensee Bucin C. Wellen 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Spirati 2 WKS Sciero 1210 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Segs Physician/Medicai Due to (or as a consequence of) pothyroidism Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Notising Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Menney of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 | Naturat 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 [] Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e, Certifier (Check only one)

State Registrar

Physician

Funeral

Director

8

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

nt of Health a If Itsem 27 is or other tra

Physician

/Medical

burial-transit

physician the burial

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Certification: To

Medical

Examiner

The law requires that the death certificate be executed

Box 68760

P.0.

Records.

Division of Vital or Attending Physicien:

this funeral

After

filled in by

completely

Hospital or Attending
 24 hours after death.
 Funeral Director: After

within 2

Baltimore, Maryland

31. Dete filed (Month, Day, Year) AUG 2 4 1999

29b. Signature and title of certifier

Honatun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

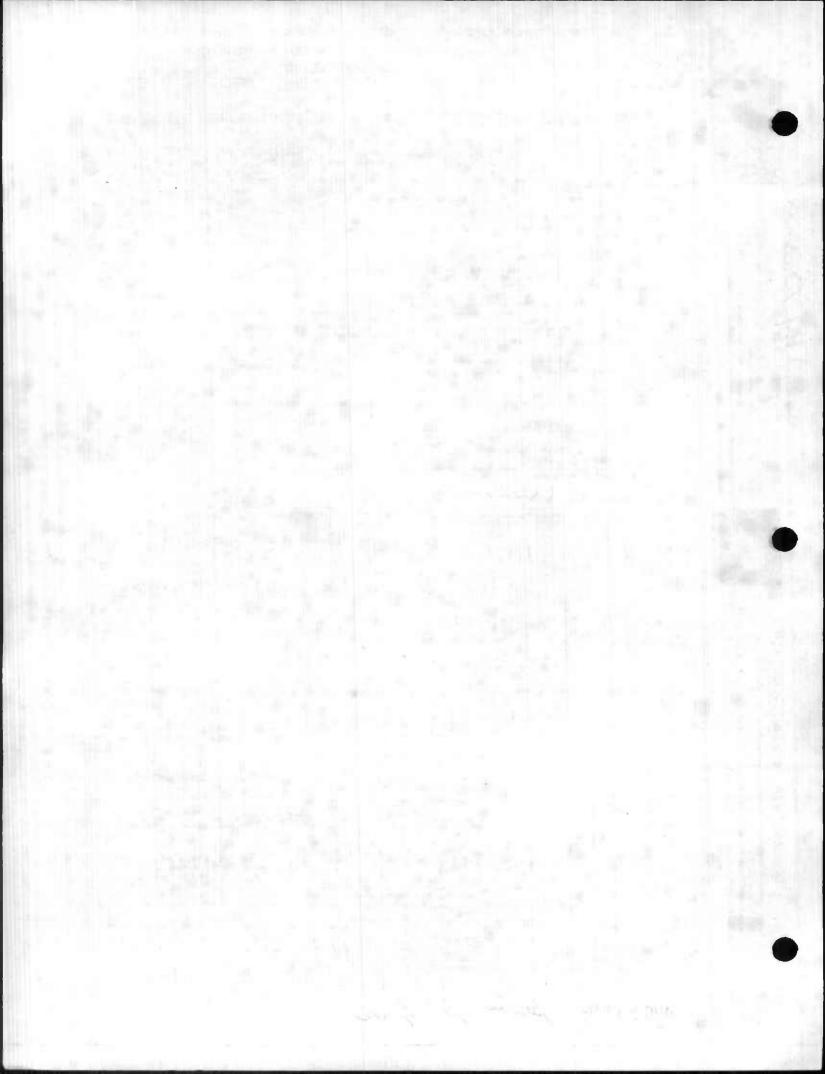
NAFEM SOID CIPHIN ST 32. Registrar's Signature

M Macon Mp

DHMH 16 Rev 6/95

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** atherine August 1700 hrs /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner of Baltimore Baltimore Universit Maryland Hospita 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthdey) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Director 210-22-5000 May 24, 1930 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Directo Delaware Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Shiloh Farms 19956 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) 12th grade Chambermaid Motel 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Emil Nahm Catherine Johanson 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Boyle (Husband) 45 Shiloh Farms, Laurel, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removel from State Cape May County Crematory 8/27/99 Lower Twp., NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care ac or respiratory arrest.

21236 Approximate intervel Between Onset and Deeth **Physician** /Medical Immediata Cause (Final Encephalopath week disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Lithosis yed r Physician/Medical Due to (or es e consequenca of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2/X No 3 Probably 4 Unknown Failure Respiratory þ 24b. Were autopsy findings evailable prior to completion of cause of death? Be Completed 24a. Was an autopsy SK No 1 Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Menner of Death 28a. Date of injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Vatural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

Records. Division of Vital

Hospital or Attending Physician: The law requires that the death certificate

signed by

this

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the

Box 68760.

P.O. 1

State Registrar

DHMH 16 Rev 6/95

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Norms 23a

'natural', or

pennit. Pages 1 and 2 should be l Department of Health and Mental important: If them 27 is marked of any Injury or other traumstic eve

Examiner

72 hours after

altimore, Maryland 21215-0020

AUG 2 4 1999

University 31. Date filed (Month, Day, Year)

30. Name and address of person who come

29b. Signeture and title of partition

of 32. Registrar's Signature

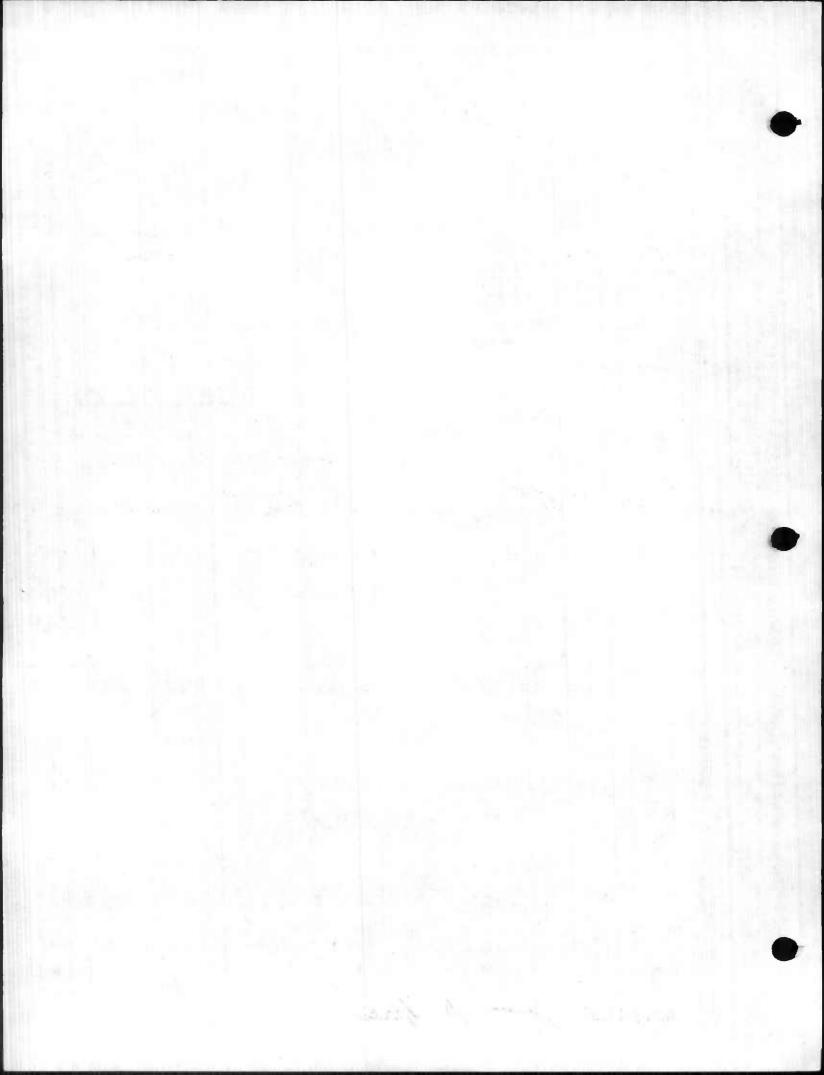
leted cause of death (Item 23a) (Type, Print) Hugo A. Torres, M.D. Maryland Hospital - Baltimore, MD.

29c. License number

P 12500

29d. Date signed (Month, Day, Year)

22



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death

29d. Date signed (Month, Day, Year)

AUGUST 18,1999

Physician /Medical Examiner

Funeral Director

288-1 re 23a or b

Director 10e. Street and Number 2414 Barclay Street 21218 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 72 hours sher 1 Yes 2 2000 If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Papes 1 and 2 should be filed within 7 nant of Health and Mental Hygiene. ant: if hem 27 is marked other than "r Elementary/Secondery (0-12) 9th Grade Cottege (1-4or 5+) Unemployed 17. Father's Neme (First, Middle, Last) William Sturgis Cinnette 19e. Informent's Name/Reletionship (Type, Print) Delores McCready 20e. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removel from Stete = 5 Department of Important: If any Injury or once. Hum of Funerel Service Licen 22. Name and Address of Fecility Physician MULTIPLE /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events and Due to (or as a consequence of): Box 68760. thet initiated events resulting in death) Lest use as the Due to (or es e consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by page 2 certificate has Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Inneral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day) 28c. Injury et Work? Affer 5 Pending investigation 1 Netural 18 To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A? 1 Yes 2 No 0107 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

572657 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 2000 Block of fuilford 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29c. License number 29b. Signature O.C.M.E m wo completed cause of death (Item 23a) (Type, Print) SMIALEK 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year)

ANTWAN D. BROWN 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Antwan D. Brown AUGUST 18 1999 3:46 A 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death NÁ 2000 BLK GUILFORD AVE BALTIMORE 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 F Months Hours 216-96-0059 18 Yrs 10-22-80 MD Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore Mary 2 □ No 10f. Zip Code 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: Black 16b. Kind of Business/Industry never-worked 18. Mother's Name (First, Middle, Maiden Sumame) Brown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 2414 Barclay Street Baltimore, Maryland 20c. Location - City or Town, State Baltimore Cemetery 08-25-99 Baltimore, MD Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death GIUNSHOT WOUNDS MINUTES 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No Yes 2 No 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 28d. Describe how injury occurred TOUND > HO 1

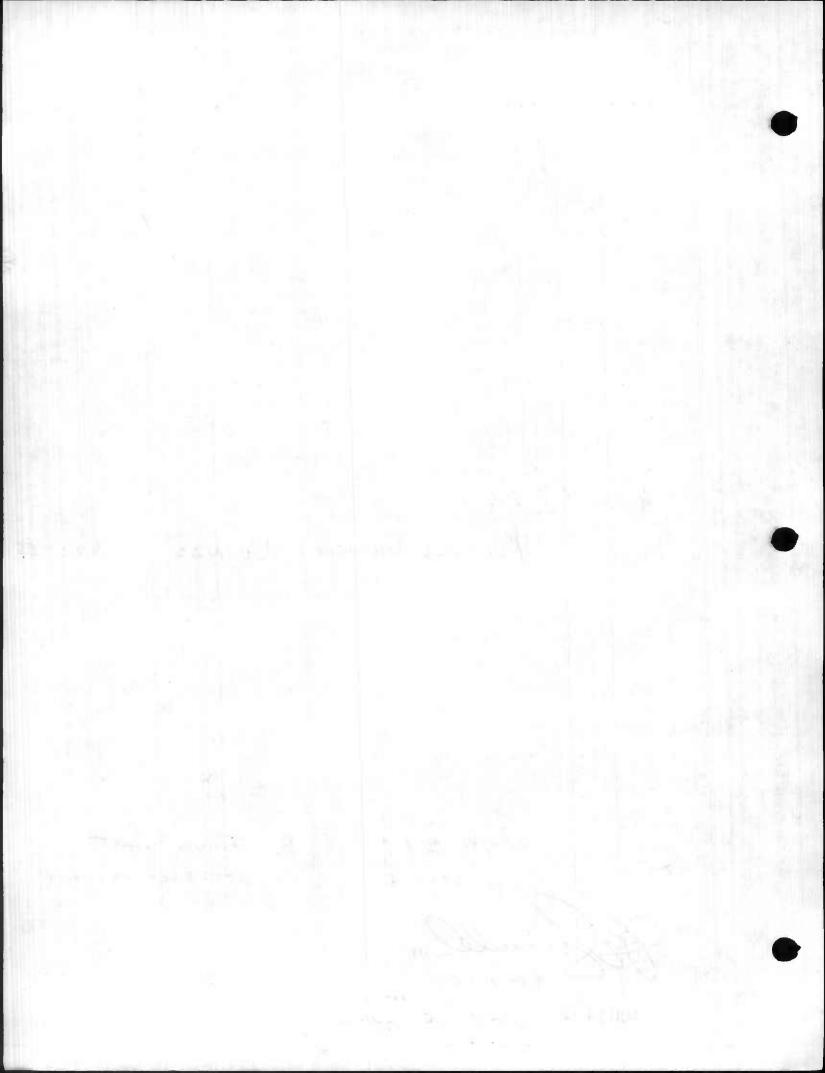
State Registrar

DHMH 16 Rev 6/95

AUG 2 4 1999

-22 Registrer's Signature

ORIGINAL



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									nd Mental Hyg	jiene				
A	MEND ITEN	M: #	23 PART I, PER MEO G774	8-24-99 WR.	С	ertificat	e of D	eath	F	eg. No. 9	3 21	5524		
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Ė	Exami	ner	4a. Facility Nama (If not institution, give		1. 1	\	46	D. \L	, or Location of Death	4c. County	of Death			
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Maryland 21215-0020	s 1 and 2 should be filed if Haalth and Mental Hyg Item 27 is marked other other traumatic event,	To Be	Joseph		Busick			J)	Jnknown)					
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JOL			1 ☐ Burial ②OCremetion 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify)	amoval from Stete	cemetary, c Green Mo	nematory or o			3/17/99	Baltim				
Baltimore,	- 5 E E E		21. Signature of Funerel Service License								020, :			
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Ö	or Al after Direc	ertif	4 ☐ Homicide dataminad	28a. Placa of injury building, atc. (5	- At homa, farm, Specify)	straat, factory	, office		28f. Location (S City or Town		er or Hurai F	toute Number,		
_	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 29a Certifying Physic Certifying	clan: To the best of m er: On the basis of axe end mannar stated	amination and/or	ath occurred invastigation,	et tha tima , in my opir	, data and p	elece, and dua to tha coccurred at tha tima, d	ause(s) and ma ata and piece,	nnar as state	ed. na cause(s)		
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			30. Nama and address of person who cor	npleted causa of daath	(Itam 23a) (Typ	e, Print)		-/-/	0 0	,	* * * *			
			Christopher Gannon	Da Sout	h Green	Δ.	et Bo	alth	ore, Maryla	nd Dis	10)			
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AMERICA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** VATHANIEL SRAHCH 0204 2 - /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** BALTIMORE HOSPITAL If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 120M 20F Months Days Hours Min 240-72-647 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inaide City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examiner must be nothed at 1KYes 2 No Director Ma mare 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 408 binson 2 should be filed within 72 hours after death in and Mental Hygiene.

Is marked other than "naturel", or itema 23s. Funeral 14. Race - American Indian. 12. Wes Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1□ Yes 20 No Specify. p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ellow IA 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Kinsle BRANCH BRANCH ice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 ie m 108 LA GRANT 20b. Place of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition any injury or conce. 1 Buriei 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) emoris 21. Signature of Funeral Service Licens 22. Name and Address of Fecility unesA CAroline 5 to be included in the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. List only one cause on each line. Approximata tntervai Between Onset and Death **Physician** /Medical Imprediate Cause (Final INTRACRAMIAL MEMORRHAGE disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last and Due to (or as a consequence of): law requires that the death certificate be exec the attending physician hed for use as the bune Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 3 Probably 4 Unknown 2 1 Yes 2 No PER TENSION Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of death? STAGE RENAL DILEASE 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 250No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Certification: 5 Pending investigation Naturai or Attending s after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 SuicIde 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital
Within 24 hours a
To the Funerel [Hospital edical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Neme and addless of person who completed cause of death (Item 23a) (Type, Print) STPAUL PLACE BALTIMORE MO 21202 COSTA 301

Registrar

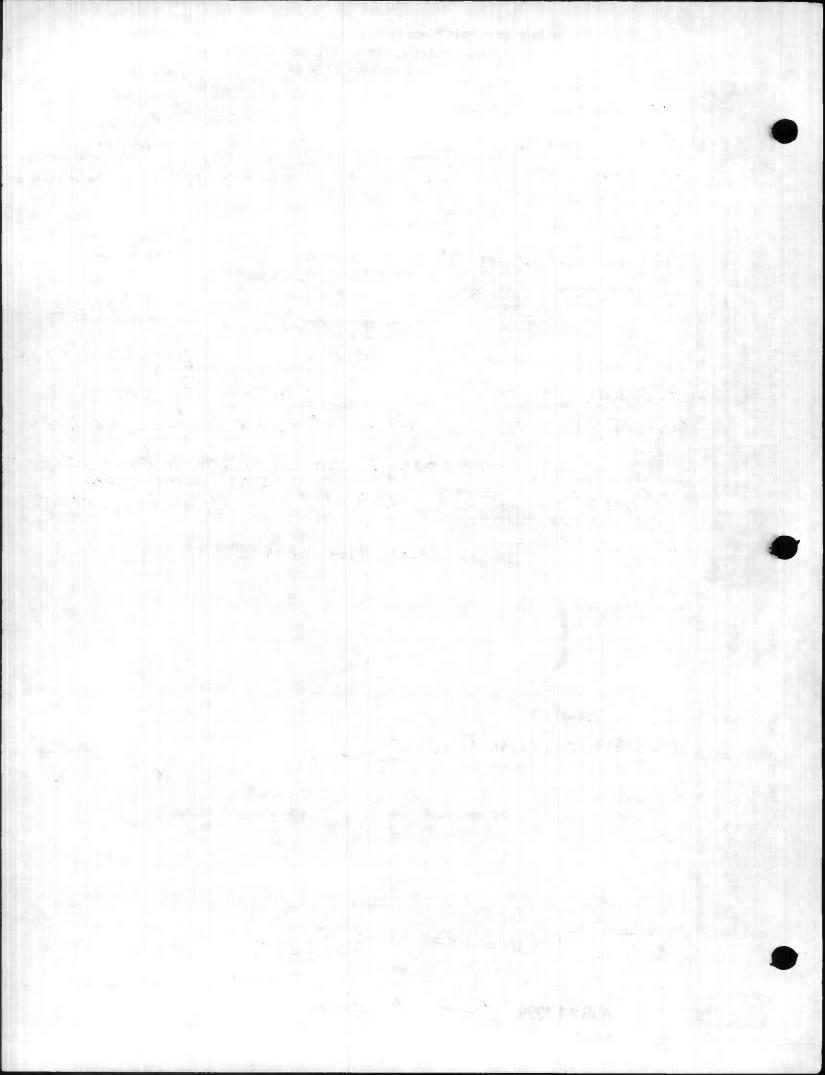
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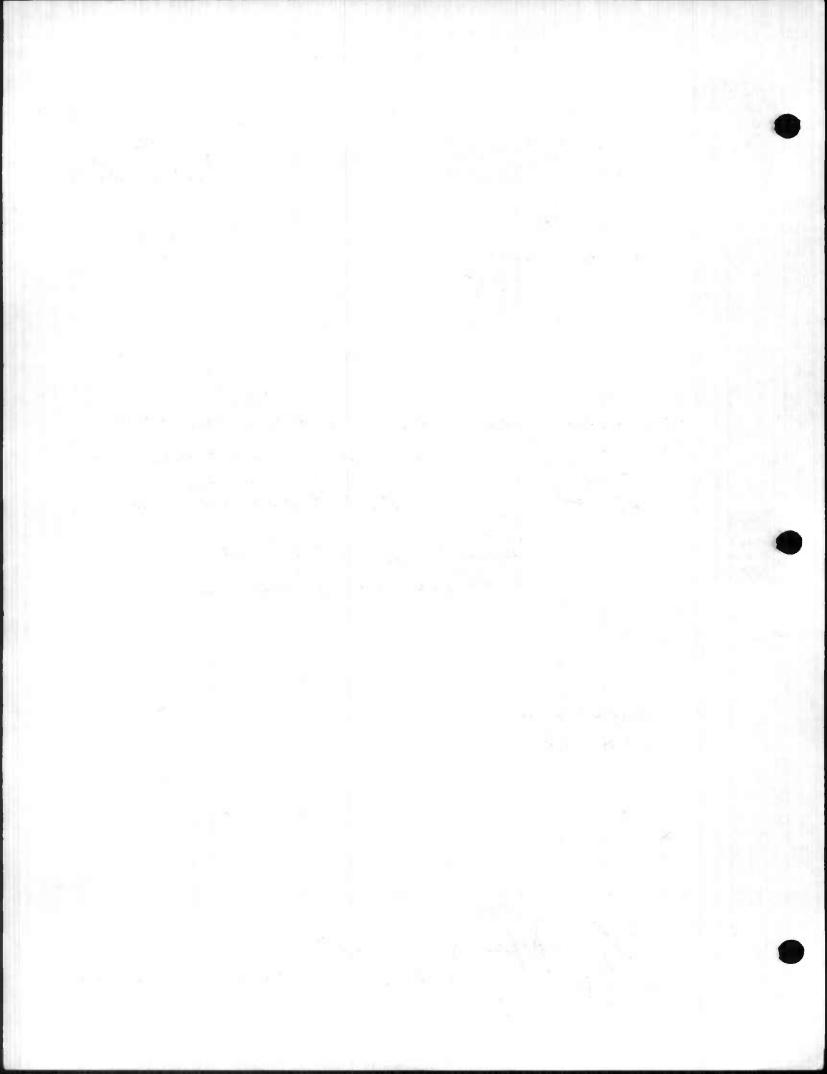
32. Registrar's Signature

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_						ertificate of	Death		g. No.	26	526	
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	show	_	10a. Stete 10b. County		10c. City, Town or L	ocation			, ,		Inside City Limits	
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21215-0020	d 2 should be filed within 72 ho th and Mentel Hygiene. 7 is marked other than "natur traumatic event, the Medical	Completed	15. Decedent's Edu (Specify only highest grad	cetion e completed) College (1-4or 5+	(Ĝiv	edent's Usuel Occu e kind of work done DO NOT use retin	during most of wor	king	16b. Kind of Businass/Industry			
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Division	Attending P ir death. ector: After i by the funer	Certification:	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Dey	Year) Injury	M 1E]Yes 2□No	28d. Describe ho				
Divi	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	building, etc.				28f. Location (Str City or Town	, State)			
	Mosi 24 ho Funt letely 1	edicai	29a. Certifier (Check only) 1 Certifying Physical Certifying Check only) 2 Medical Examination	vician: To the best of ner: On the basis of e end manner stete	examinetion end/or in	th occurred et the t nvestigetion, in my	Ime, date end plece opinion, death occu	, end due to the ce rred at the time, de	euse(s) end mar ete end plece, s	ner as steted nd due to the	J. ceuse(s)	
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	3		30. Name end eddress of person who as	mutated cause of dec	ith (Item 23a) Type	Print)	D R.	lto, L	1 2 2	123	7	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:30 A.H. **Physician** Kichara Blunt A Month

August

Bb. City, Town, or Location of Death 1999 4c. County of Death /Medical 4s Facility Name (If not institution, give street and number) Examiner BALTINORE . SaeatoGa If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days 213-07-2553 Director **Usual Residence of Decedent** filed within 72 hours efter deeth with the Maryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No Director NI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or .S.A Sale toga 21223 2019 12. Was Decedent Ever in U,S. Armed Forces?

1 □ Yes 2 □ Mo
If Yes, Give
Year or Dates: Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Peges 1 and 2 should be filled within 72 hours efter dinent of Heelih and Mentel Hyglene.
Int: If Hem 27 ie marked other than "natural", or ham int or other treumatic event, the Medical Examination Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Uaxter Oth grade wong shoreman 17. Father's Name (First, Middle, Last) UN Known 18. Mother's Nama (First, Middle, Maiden Surname) hula Hal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print). Coldspring Jeborah Jou 2 5 Balto, Md 21212 DAUCH Lane 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20g. Location - City or Town, State pamil. Peges
Department of
Important: If it
eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/19/ Name and Address of Facility 21 58 e of Funeral Service Licens Balto, My Avenue 212/5 00 wahash 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hourt follows. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 64 Examiner Due to (or, as a consequence of) Physician/Medical Examiner g physicien and es the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): signed by the ettending be deteched for use P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investiga 24 hours efter deeth. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier completely

State Registrar

29b. Signature and title of certifier

e and address of person

DHMH 16 Rev 6/95

within 2 \$

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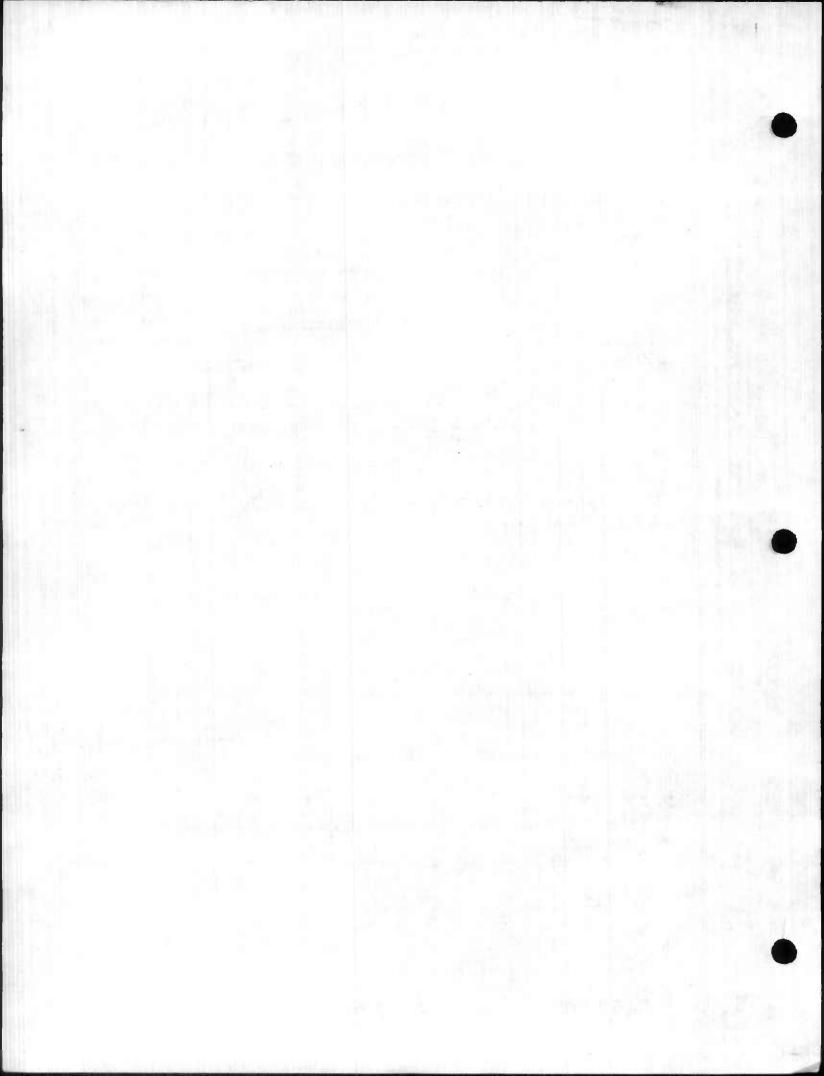
ted cause of death (Item 23a) (Type, Print)

300 Armory Hagistrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

99



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) **Physician** 2:50 Am Angers 20 masine /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner emor 7. Aga (In yrs. last birthday) a MOD If Undar 24 Hrs. 5. Social Security Number 6. Sax 9. Birthplaca (Stata or Foreign **Funeral** 10 M 20 Months Days Hours Min 216-316-54-426L Usual Rasidance of Decedant Yrs. Director VITGINIA death with the Maryland 10a. Stata 10b. County 10c. City, Town of Location 10d. Insida City Limits I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified as Md 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 0 SON 10 Funeral Was Decedant of Hispanic Origin? (Specity Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Baca - American Indian 11. Marital Status Biack, Whita, atc. parmit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or fre-1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 PDivorced Black Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working lifa., DØ NOT use retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Cellega (1-4or 5+) touse wife 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middle, Last) Be and Mental H To Spencer TIE 4.1 19b. Meiling Addrass (Streat and Number or Rural Flouta Number, City or Town, State, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 815 11155 Famela Barnes 20a. Mathod of Disposition Md. 2/207 Daltimor 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata injury or □ Donation 5 □ Other (Specify) 21. Signature of Funeral Seprice Lice 22. Nama and Address of Fecility funeral, Home 5 ane 2222 W. North Balto, md. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final BI/atun disaasa or condition rasulting in daath) Examiner Examiner sician and burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in deeth) Last Dua to (or as a consequanca of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequance of): Se usa õ signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings svailable prior to Completed 24a. Was an autopsy performed? complation of cause of death? page 2 has 2 No 1 Yes 2 No cartificate Hospital or Attending Physician: funeral director. 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1º Inpatiant 2 □ ER/Outpatient 3 □ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 24 hours after death. 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, larm, straat, lactory, office building, atc. (Specify) 4 - Homicida v☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staled.

2☐ Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical completaly (Check only one) To the I within 2 29b. Signature and title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year)

Memors

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30. Nama and addrass of person who complated causa of death (tram 23e) (Type, Print)

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32. Pyristrar's Signetura

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DHMH 16 Rev 6/95

State

Registrar

March

31. Data filed (Month, Day, Year)

AUG 2 4 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Paul Μ. Brooks August 19, 1999 4:20 PM 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth The Keswick Home Baltimore If Under 1 Yeer If Under 24 Hrs. Months Devs Hours Min. 5. Sociei Security Number 8. Dete of Birth (Month, Day, Year) Jan 11, 19 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 215-01-7700 XDM 2DF Deys Yrs. 84 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A X1X Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3838 Roland Avenue Apt 903 21211 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 C\No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 X Merried 1 ☐ Yes XNo Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elamentery/Secondary (0-12) Coliaga (1-4or 5+) Rrinter Printing 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surnama) William Henry Brooks Nona Breashears 19a. Informent's Neme/Reletionship (Type, Pnht) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Geraldine Brooks (Wife) 3838 Roland Avenue Apt 903, Baltimore, Maryland 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stete Meadowridge Memorial 8/23/99 Dorsey, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Faparel Service Licensee 22. Neme end Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at

Funeral Director

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Completed

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I Hygiene.

permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Hyglent Importants: If item 27 is marked other that any injury or other traumatic event, the pages.

21215-0020

Baltimore, Maryland

Physician/Medical þ Completed Be 2 Certification:

To the Hospital or Attending Physician: The law requires that the deeth certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detected for use as the bunkel transit

Division of Vital Records, P.O. Box 68760,

resulting in deeth)	е.	mone	a		3 days					
		or es a consequence of)		•						
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Ceuse (Disaese or Injury thet initiated evants rasulting in deeth) Last	C Due to (or as e consequence of):									
Pert II. Other significant conditions or	d.	ula in a la Alan condestado a		ant Pidas						
Shy-Dragor	. (cause given in Part I.	1 ☐ Yes 2 ₽ No	ontribute to the cause of death 3 Probably 4 Unknow					
	,			24e. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth?					
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25. Wes cese referred to medicel			26. Pleca of D	eath (Check only ona)						
exeminar? Hospital:		OA Other: 4 M Nursing	ing Home 5 ☐ Residence 6 ☐ Other (Specify)							
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exeminar? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Panding Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)		28c. Injury et Work? 1 ☐ Yes 2 ☐ No							

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29b. Signature and fil

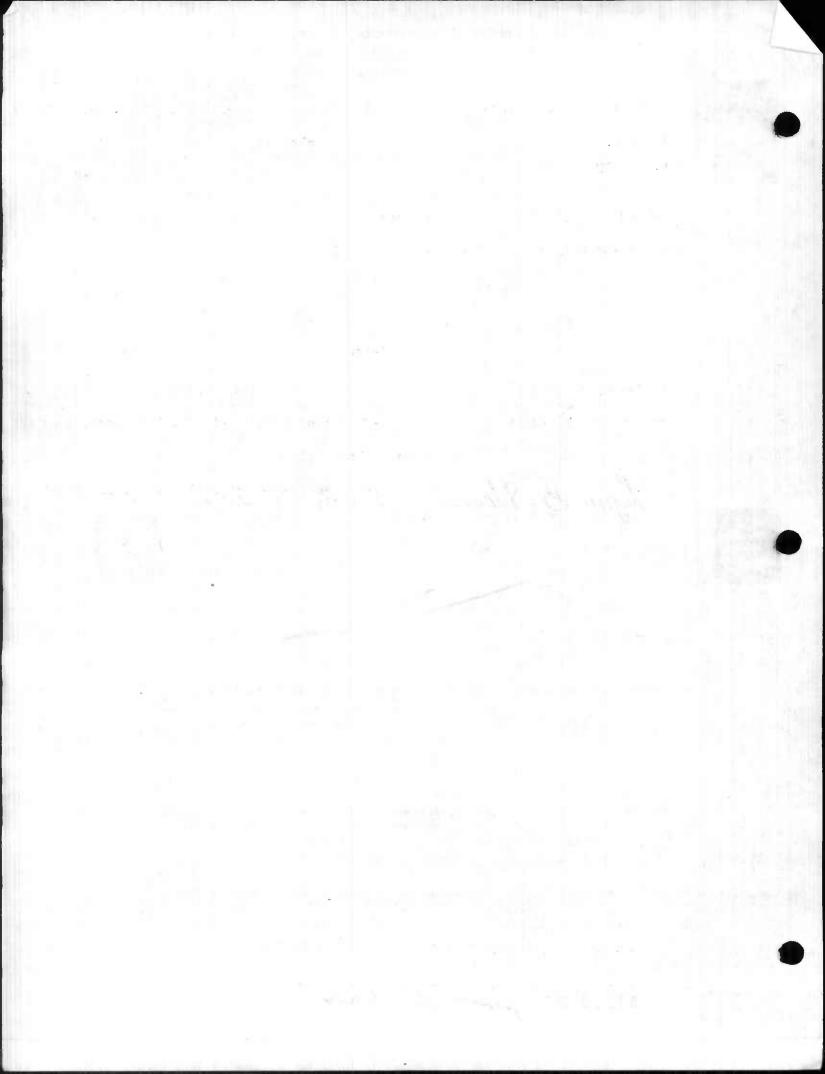
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usa of deeth (Item 23a) (Type, Print)

29c. License number

29d. Dete signed (Month, Day, Year)

To 1 Street BALTIMORE



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	/Medi Examir		4e. Fecility Neme (If not institution, give	street end numbe	nr)		4	lb. City, Town, or	Location of Deeth	4c. County	of Deeth		
			Saint Joseph				Hilladay 4 Van	Tows		E	alti		
L	Funeral Director		210 00 /21/	9X 7. / ☐M 2☐ F	Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.	8. Dete of Birth June 9	Year 912	9. Birthpl Mary	ece (Ste Lan	te or Foreign d
	yland	Director	Usuel Residence of Decedent 10a. Stale 10b. County			ty, Town or Loc	cation				10		e City Limits
	he Mar		MD. Baltimo	re	Tow	son	100 70 0 1						es 2 No
	3a or	al Dir	10e. Street end Number 28 West Alle	gheny A	ve #	1904	10f. Zip Code 2129	21204	10	g. Citizen of V US		iry?	
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	Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)			RY FAI						Onset e	nd Deeth
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o.	the the	Physician/M	Pert II. Other significant conditione or	entributing to death	but not res	sulting In the un	derlying cause giv	23b. Did tol	Bb. Did tobecco use contribute to the cause of deeth?			se of deeth?	
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al B	The ate h	1 7 1	25.14	_					1 □ Ye	/	1	Yes :	No
f Vital	Physician: this certific ral director,	o Be	25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 Inpa	tient 2	ER/Outpetlent	3□ DOA Oth	or:	ath <i>(Check only one</i> fome 5 ☐ Reside		er (Specify	·)	
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Division	deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	200. Place of I	njury - At h etc. (Specia		M 1	Yes 2 □ No	28f. Location (Str City or Town		er or Rura	Route N	lumber,
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			30. Name end eddress of person who of FRANCIS KHOO M					OWSON,	MARYLAN	ND 212	04		
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Physician /Medical Examiner

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Records, P.O.

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Physician

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7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Experient must be not that at

the Maryland

72 hours efter

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Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Physician/Medical

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 1 Naturai 5 Pending investigation 2 Accident 6 Could nof be determined 3 Sulcide

28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 □ Nursing Home 5 ■ Residenca 6 □ Other (Specify) 28c. fnjury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

(Check only one 290. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the ceuse(s) and manner stated. 29c. Licanse number 29d. Date signed (Month, Day, Year) 21776

AUGUST 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURVA P 300 3001

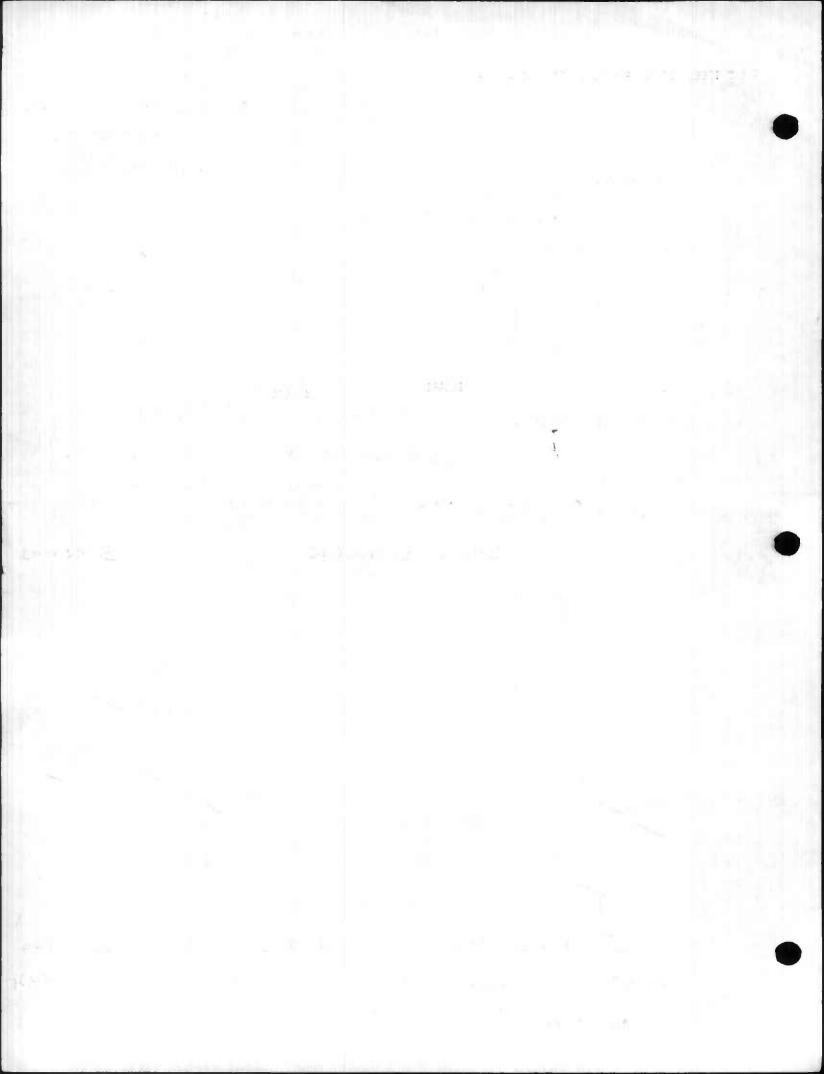
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State Registrar

AUG 2 4 1999



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Hyust 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Baltimore AR Chinversit mana If Under 24 Hrs. Hours Min. 8. Dala of Birth (Month, Day, Year) 5. Social Security Numb 6. Sex If Under 1 Ye 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 10 M 200 F Months 2804 36 MI 80. 11-03 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE NIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA WAINUT VENUE 12. Was Decedent Ever in U,S. Armed Forces?/ Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, etc. 11. Marital Stalus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

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23a. Part1. Enter the dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

20b. Place of Disposition (Name of cametery, crematory or other)

STERN STAR (

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SERVICE

MD.

2 No

20c. Location - City or Town, Stata

21208

Approximata Intervel Batween Onset and Death

3 Probably 4 Unknown

24b. Ware autopsy tindings evailable prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

18. Mother's Name (First, Middle, Maiden Sumame)

Dala

8-28-99

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

PIKE,

ROCKETT

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NATL

22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL

permit. Pages 1 and 2 a Department of Health an Important: if Nem 27 le I any injury or other treu once. **Physician** /Medical

Physician

/Medical

Examiner

10a. Stata

701

MD

Elementary/Secondary (0-12)

17. Father's Nama (First, Middle, Last)

SLOWE

CROCKETT

1 Ø Burial 2 ☐ Cremetion 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

GED

ALVIN

20a. Method of Disposition

MARY

Funeral

Director

v 28e-f show

"natural", or items 23a or

Pages 1 and 2 ahould be filed within 72 hours efter or ment of Health and Mental Hyglene. ant: if frem 27 le marked other than "natural", or her ury or other treumatic avent, the Medical Emerinary

Baltimore, Maryland 21215-0020

Director

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Completed

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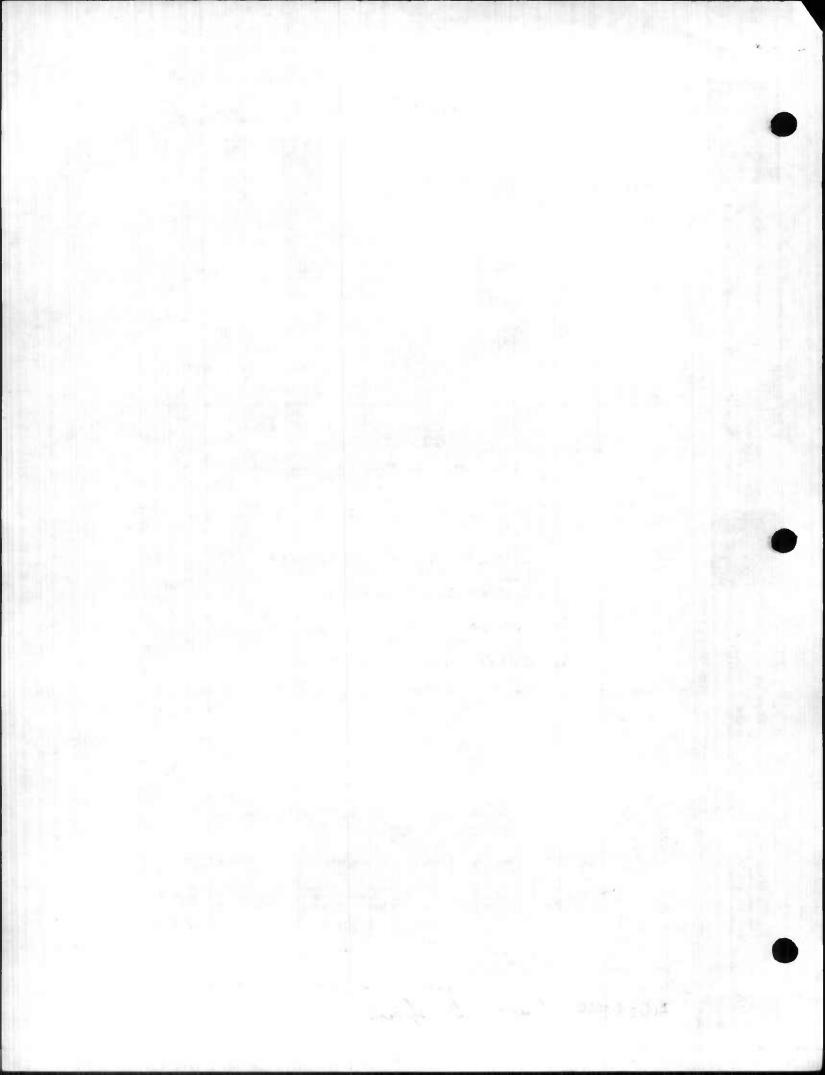
Box 68760. 188 P.O. Records, page 2 Division of Vital or Attending Physician: this funeral After death. filled in

Immediate Causa (Final diseasa or condition resulting in death) Examiner Examine sician and burlei-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury thal initiated events resulting in death) Last Due to (or as a consequence of) physician the burle Physician/Medical ere Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2 No þ edical Certification: To Be Completed 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturat
2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of curtifie 29c. License number 29d. Dala signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5. Geeene 32. Registrar's Signature State Registrar

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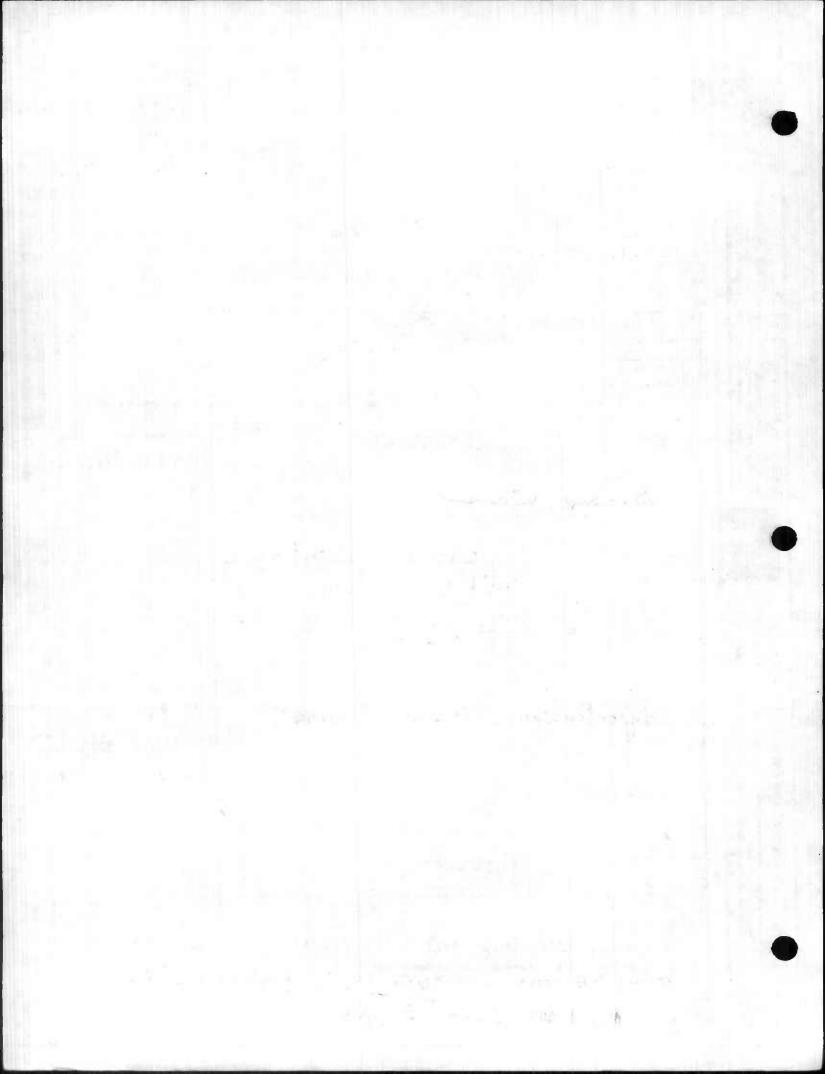


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State of Maryland / Department of Health and Mental Hygiene 99 26

						, , , ,		Certi	ficate of	Death		Reg. No.	9 6	6533	
	5 1		Decedent's Name (First, Middle, Last)									2. Data of Death 3. Tima of De Month Day Year			
	Physiciar /Medica		arlen	9				Cape	rs		August		999	6:00 a.m.	
6.	Examine	4a Fa			, give street and	number)				4b. City, Town, or	Location of Deat	h 4c. Coun	ty of Deeth		
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	Funeral Director	249-	al Security No -68864	16	6. Sex 1 ☐ M 2 🖾 F	7. Aga (In	yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th. Year) 0 1941	9. Birth Cou	place (State or Foreign ntry) S.C.	
	P	Usual 10a. S	Residence of	Decedant 10b. County		10	c. City, Tow	m or Loca	tion					10d. Inside City Limits	
	Aenyla dan		Md	N/A										1 ¥ Yas 2 □ No	
	vith the Me or 28a-fa	10a S	reet and Num			Be	ltimo	re	10f. Zip Code			10a Citizen o	. Citizen of What Country?		
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	State	31. Dai	a filed (Monti	, Day, Year)	32.	Registrar's		4	low					Ring	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ockha IRCLE If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours -28-4555 1 MM 2□ F Yrs. Director 0 Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 21050 "natural", or items 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 1 ØYes 2 ☐ No If Yes, Give 14. Race - American Indian. 11. Marital Stetus Black, White, etc filed within 72 hours after thygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 XNo Specify by 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hopkins JOHNS Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygient important: if Nem 27 is marked other tha any Injury or other traumetic and any Injury or other traumetic and any Injury or other traumetic ngiller 17. Father's Name (First Middle Last) (1B. Mother's Name (First, Middle, Meiden Sumeme) Be UNKNOWN 2 19g, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2073 handler 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 14 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Valley Mem. Gans 22. Name and Address of Fecility 4 □ Donetion 5 □ Other (Specify) IMONIUM. Chapel 21. Signature of Egneral Service Licenses EVANS Funeral BelAIR Pert1 Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 0 5 CV disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Due to (or as a consequenca of): physician Box 68760 Physician/Medicai the Due to (or as a consequence of): USB Pert II. Other staniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 94 signed by the 3 □ Probably 4 ☑ Unknown 1 TYRE 2 No Completed by 24b. Were autopsy findings available prior to 24e. Wes an autopsy peen completion of cause of death? page 2 1 □ Yes 2 □No certificata or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yes 2□ No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Director: After 5 Pending n 24 hours after death. The Funeral Director: After plately filled in by the fur 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

AUG 2 4 1999

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

To the Pwithin 2.

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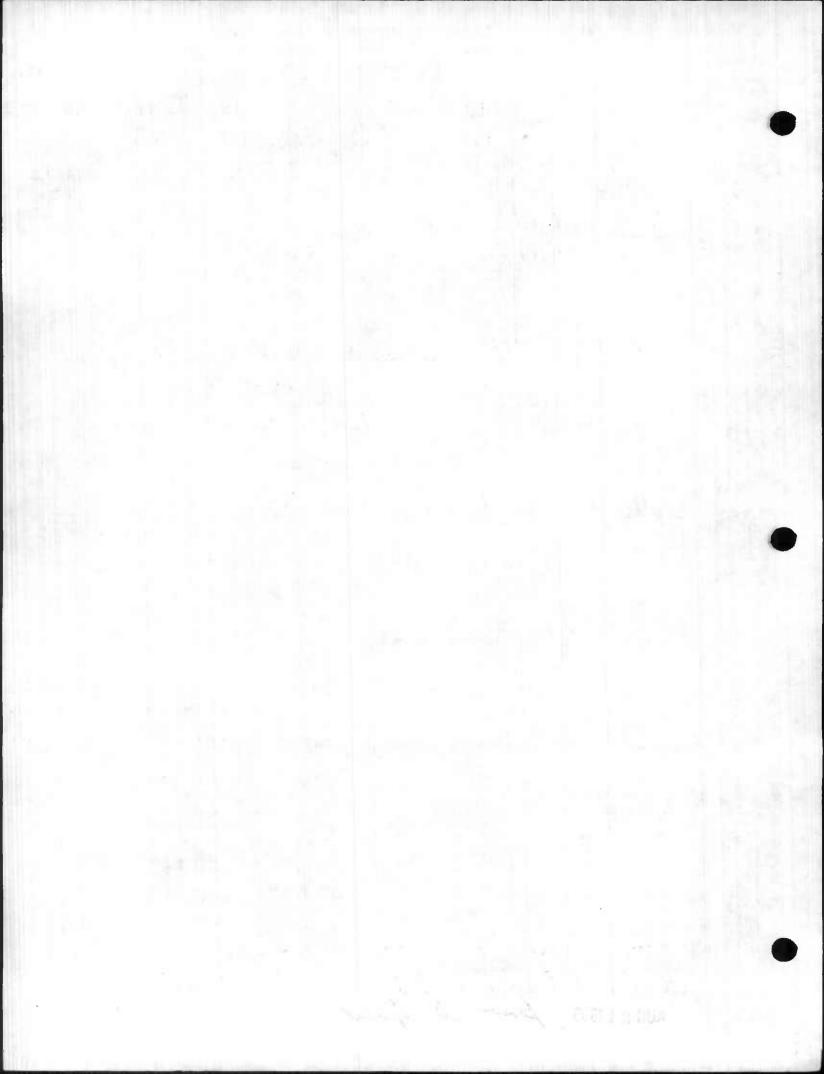
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32. Registrar's Signature

29c. License number

29d. Date signed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene 99 26535

CRO	OWFFEY				Certificat	te of Death	F	leg. No.	2 6	.0000		
	Dhunini		1. Decedent's Name (First, Middle, Last)	1 .00	0		2. Date of Dea Month	th Day	Year	3. Time of Death		
	Physici /Medic		Vernon E.	Crowtte	V Sr.		AUGUST		999	5:15 PM.		
	Examin		4a Facility Name (II not institution, give	treet and number)		4b. City, Town, or I	Location of Death	4c. County	of Death	1		
			UNION MEMORIAL	HOSPITAL		BALTI			NIF	†		
	Funeral Director		5. Social Security Number 2 18-42-3395 Usual Residence of Decedent	M 2 F 53	Yrs. If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	49946	9. Birthp	laca (State or Foreign try) (IAN Q		
	show dat		10a. State 10b. County	10c. City, To	wn or Location				- 1	0d. Inside City Limits		
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020	ors after	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1□ Yes	2 No Specify:		Specin	icar	America		
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ore	of the state of th		20a. Method of Disposition	a coma	of Disposition (Ne tery, crematory or	me of other place)	Date	20c. Location -	City or To	wn, State		
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) h	Lan		O.C.M.E.		AUGUST	15, 1	.999		
		1	30. Name and address of person who co	pleted cause of death (Item 23s) (Type, Print)		1					
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death **Physician** 10 1999 11.12 pm /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Dunth 4c. County of Death Examiner Herseral County er 6. Sex LIRAL HOSALS 7. Age (In yrs. last birthdey) 10 5. Social Security Number If Under Deta of Birth (Month, Dey, Birthplace (State or Foreign
 Country) **Funeral** Months Deys Hours 1XM 20 F Pennsylvania -3829 -12 Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10d. Insida City Limits 10c. City. Town or Location 28a-f show injury or other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 63 permit. Pages 1 and 2 should be filed within 72 hours after death w
Department of Heelth and Mentel Hygiene.
Important: If flam 27 is marked other than "natural", or flams 23a
any injury or other traumatic ayant. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - Amarican Indian, Black, Whita, etc. 11 Marital Status ☐ Yas 2 No Yas, Give 1 Never Married 2 Married 1 Yas Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Marietta MARYLN Elementary/Secondary (0-12) College (1-4or 5+) LUKENOWA 18. Mother's Name (First, Middla, Maidan Sumame) 17. Father's Name (First, Middle, Last) Be Meich 4 nna 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) olumbia. 21045 Ma Wile 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 21 Aug. 1 Burial 2 Cremation 3 Removal from State Dulakey Valley Mem. Galus Maryland 4 ☐ Donation 5 ☐ Other (Specify) Imonium 21. Signatura of Edneral Service Licensee 22. Name and Address of Facility Funeral Chapel WANS Harterd 21234 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Causa (Final Isease disease or condition rasulting in daeth) yeurs Examiner Examiner (nges bunal-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting In death) Last Due to (or as a consequence of) and physician s s the bunal-Box 68760. Physician/Medical Due to (or as a consequence of) 88 950 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the a Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? has page 2 2 No certificate 1 Yas 1 ☐ Yes 2 No Division of Vital 25. Was casa rafarred to medical exeminer? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ■ ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of Certification: 28c. Injury at Work? within 24 hours after deeth. To the Funeral Director: After or Attanding 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar edicai (Check only one) To the 29b. Signatura and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 266 tho completed causa of death (Item 23a) (Type, Print) 30. Nama and addrass of person 3460

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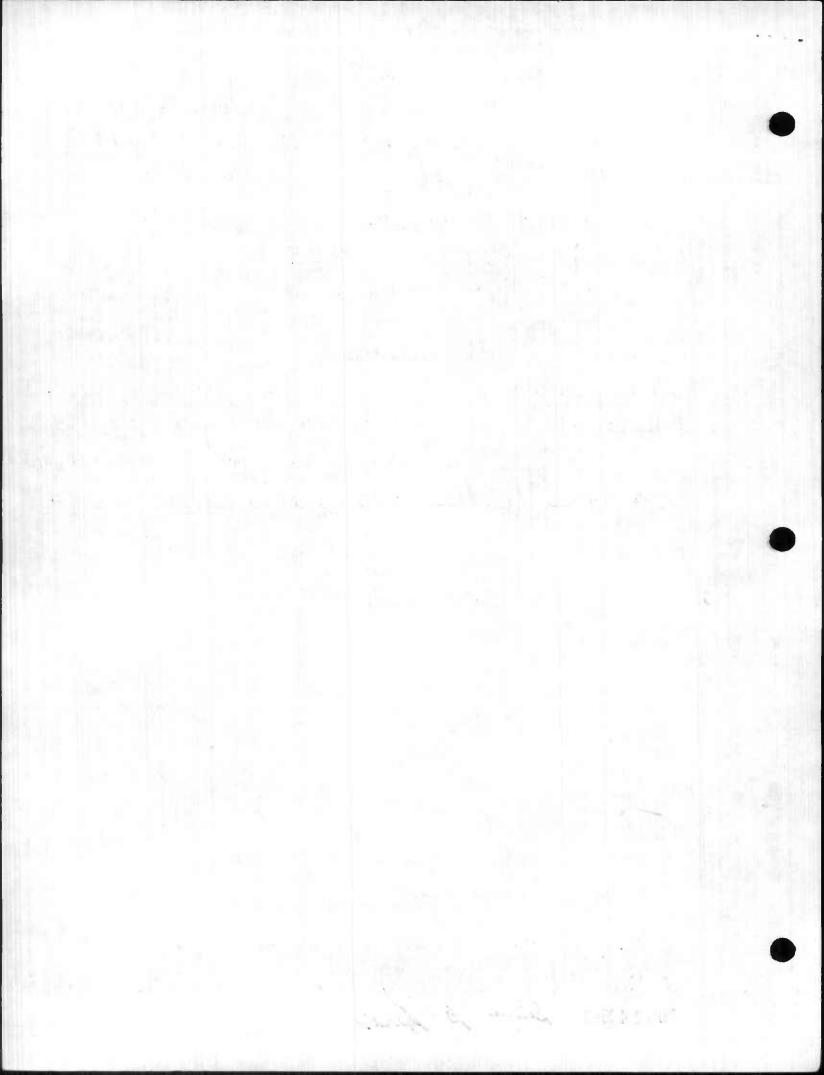
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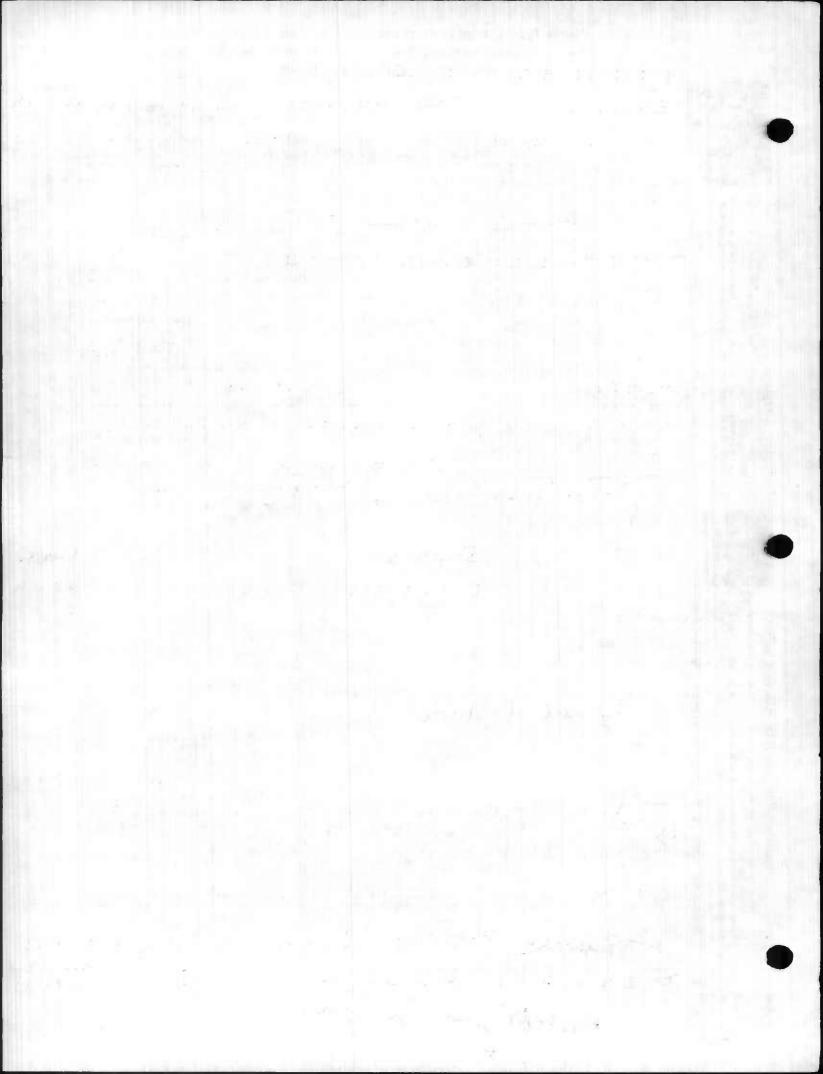
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32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	AMEND#10c,10e & 10	of PER F.H. G775	5 9-1-99 J.A	Lertificate of	Death	2. Date of Dea	leg. No.	3	Time of Death
sician	ETHEL	coo, Lusty	DRO	NEBUR	-6	Month	Day	M	310 AM
edical miner	4a Facility Neme (If not institut	ion, give street end numbe	or)		4b. City, Town, or		4c. County		
	Good Samarita	-			Baltimor			N/A	
ral	5. Social Security Number	6. Sex 7. /	Age (In yrs. last birtl 83 Y	rday) If Under 1 Year Months Days		8. Date of Birth (Month, Day June 9,	(Year)	9. Birthplace Country)	(State or Foreign
tor	217-22-1898 Usual Residence of Decedent		0.0			Julie 9,	1910		N.C.
	10a. State 10b. Coun	ity	10c. City, Town	or Location				10d. ir	nside City Limits
ctor	Md. Ba	ltimore	Balti	more TO	WSON			1	Yes 20 No
23a or 28a-fa uni be northed al Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W		
ral	10 Decatur Rd.		UEHANNA AVE	-21220	21200			USA e - American In	dian
by Funeral	11. Maritel Status 1 Never Married 2 Maritel 3 Widowed 4 Divorce	If Vac Give	s? ② No	13. Wes Decedent of in the Yes, specify Cub 1 ☐ Yes 2 ☑ No	pan, Mexicen, Puerl	pecny Yes or No- o Rican, etc.)		k, White, etc.	
		ent'a Educetion	16a. l	Decedent's Usual Occu	pation	dring	16b. Kind of Bu		
Completed	Elementery/Secondery (0-12	nest grede completed)) College (1-4o	or 5+)	Give kind of work done life. DO NOT use retire	ed)				
S	12	- f - A	Ma	chinist	T 40 Mark and Mark	ne (First, Middle,	Black &		
Be	17. Father's Name (First, Middle John H. Durham				Ophelia		walden Sumam	θ)	
70	19a. Informant's Name/Relatio		19b.	Meiling Address (Stree	-		r. City or Town.	State, Zip Code	e)
	Mr. Clyde T. D			Decatur R					
	20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other ple		Date	20c. Location -	City or Town, S	State
	1 ☑ Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		le .	y Valley Me		8/20/99	Timoni	um. MD.	
DUCE.	21. Signature of Funeral Septic	Krawhod UU		22. Name and Addre Ruck Tows	ess of Facility				
a	- state	DEN	>	1050 York					
	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ceus ist only one ceuse on eech	ed the deeth. Do not line.					Inte	roximete rval Between
in al	Immediate Cause (Final		et and Death						
er	disease or condition resulting in death)	Θ	Sepsi Due to for es e c	S				1	lucek
وَ			Teilul						north
Examiner	Sequentially list conditions,								
- X	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	,						Į.	
dical	that initiated events resulting in deeth) Lest		Due to (or as a co	ensequence of):				1	
-		d						1	
clar	Don't Other planificant condi	Alama aantsibutina ta daath	but and marking in	the condedition course of	iven in Deat I	22h Did e	abassa usa sar	atelliuse so she	cause of death?
Physician/M	Part II. Other significent condi	al fai		ure uncerrying cause gi	von in Feit I.	230. Uid t	obacco use cor		cause of death? 4 ☐ Unknown
by P	LEN	m Tai	IMPE				-/-		
Completed						24a. Wes o	en autopsy med?	evallebl	utopsy findings le prior to tion of ceuse 1?
Com						1 🗆 Y	es 2 No	1 ☐ Yes	2 No
Be	25. Was cese referred to medic examiner?					ath (Check only o	ne)		
5	1 ☐ Yes 2 No	Hospitel: 1 1 Inpa		Datient 3LI DOA		lome 5 Resid			
lon:	27. Manner of Death 1 Natural 5 ☐ Pendinya	arrig			rry et ork?] Yes 2 □ No	28d. Describe h	ow injury occurr	90	
Certification:	3 ☐ Sulcide 6 ☐ Coul	d not be milned 28e. Place of	Injury - At home, fan			28f. Location (S		er or Rural Rou	ite Number,
erti	4 Homloide	building,	etc. (Specify)	n, street, factory, office		City or Ton			
0	29a. Certifier (Check only one) Certify	ring Physicien: To the besing Examiner: On the basis end menner	of examination and	death occurred at the ti for investigation, in my	ime, date and place opinion, deeth occu	o, and due to the d pred et the time, d	cause(s) and ma date and place, a	nner as stated and due to the	cause(s)
dical				29c. Licen	se number		29d. Dete signe	d (Month, Day,	Year)
Medical	29b. Signature and title of certif	fier DI	ALLCIN'A	4					
edical	29b. Signature and title of certif	lahus Pl	mysicia	DOG	543	03	Augu	st 18,	1999
edical	30. Name and address of person	dahus Pl	I deeth (Item 23e) (1	1200		o3	Augu 5601 L Baltime	st 18, och Re ore, Ms	1999 2 21239



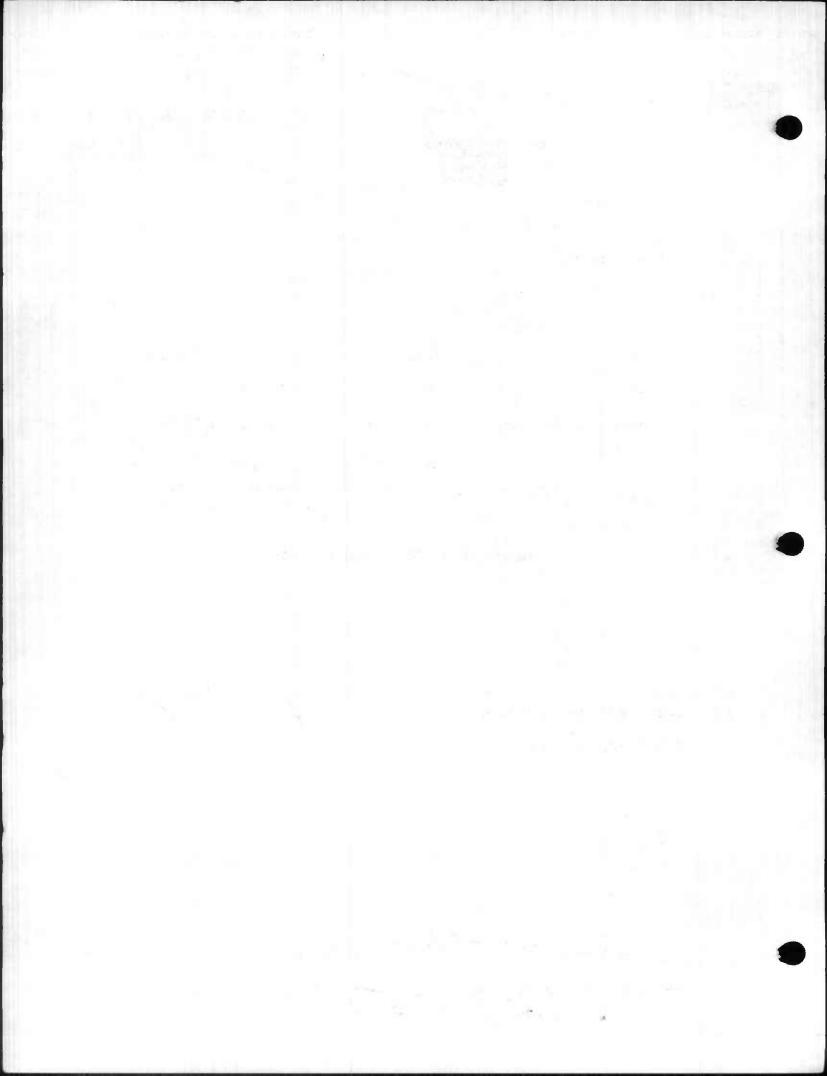
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month MARTIN BISSET DODD 4c. County of Death /Medical 4b. City, Town, or Location of Death 7:43 PM 4a. Facility Name (If not institution, giva streat end number) TOWSON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yaar)
Dec. 22, 1918 **Examiner** Saint Joseph Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 216-07-8138 80 Md. Director Usual Rasidence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 Tyes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Haalth and Menial Hygiana. Important: If item 27 is marked other than "naturel", or items 23a and injury or other treumatic event, the Medical Examinar sonce. 1643 Mussula Rd. Funeral 21286 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: WW—II Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 Widowed 4 Divorcad White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Engineer Westinghouse 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Dodd Virginia William Smith 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Jeanne G. Dodd/wife 1643 Mussula Rd. Towson, Md. 20b. Placa of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/26/99 Towson, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires thet the death cartificate be assecuted 24 hours after death. Fureral Director, Atter this certificate has been signed by the attending physician and staty filled in by the funaral director, page 2 should be detached for use as the burial-transit Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown GASTROINTESTINAL BLEEDING Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was en eutopsy performed? Completed ATELECTASIS OF LUNG 2 No Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatiant Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. tnjury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicida 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled edical Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end manner as steted.

2 Medicat Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and pleca, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D-30263 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND
31. Deta filed (Month, Dey, Year) 32. Registra's Signature State AUG 2 4 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month 18 1999 4:50 P.M. Carmella Mary DeRicco August 4a Fscility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill Harford 8. Date of Birth (Month, Day, Year) April 12, 5. Sociel Security Number 6. Sex 7. Age (tn yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days New York 1□M 2\ F Months Hours 80 1919 104-01-5602 Usual Rasidance of Decedent 10d. Inside City Limits 10b. County 10a State 10c. City. Town or Location 1 Ty Yas 2 □ No Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 N. Pine Ridge Court 21014 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 210 No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 21 No Specify: Specify: 3 N Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondery (0-12) College (1-4or 5+) 11th grade Telephone Operator Phone Co. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Frank Laudanno Anna Cappetta 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) Josephine D'Anna (Sister) Bel Air, MD. 21014 812 N. Pine Ridge Court, 20a. Method of Disposition 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata 4 Donetion 5 Other (Specify) 8/23/99 Florida National Cem. Bushnell, Florida 21. Signatura of Funaral Saprice Licensee 22. Name and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset end Deeth Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immedieta cause. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

certificate be execu Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Directo

à

Completed

Be

Funeral

Director

2

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens. Important, if New 27 is marked other than "n any Injury or other treasment.

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or itsens 23s or 28s4 show traumetic event, the Medical Examiner mast be notified at

Examine attending physician and for use as the burial-transit Physician/Medicai detached signed by 1 d be detact by Completed Be To funeral Certification:

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 24b. Ware eutopsy findings available prior to complation of causa of death? 24a. Wes an autopsy performed? 1 Yas 2 No 26 Place of Death (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural

1 □ Yas 2 No 25. Was case reterred to medical examiner? Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and manner stated.

D32299

29b. Signatura and titla of certifiar

29c. License number 29d. Data signed (Month, Dey, Year)

August 13, 1975

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Dov. D 615 00. 5 DUN 31. Dete filed (Month, Day, Year)

State

edicai

AUG 2 4 1999

32. Registrar's Signatura

Registrar **DHMH 16 Ray 6/95**

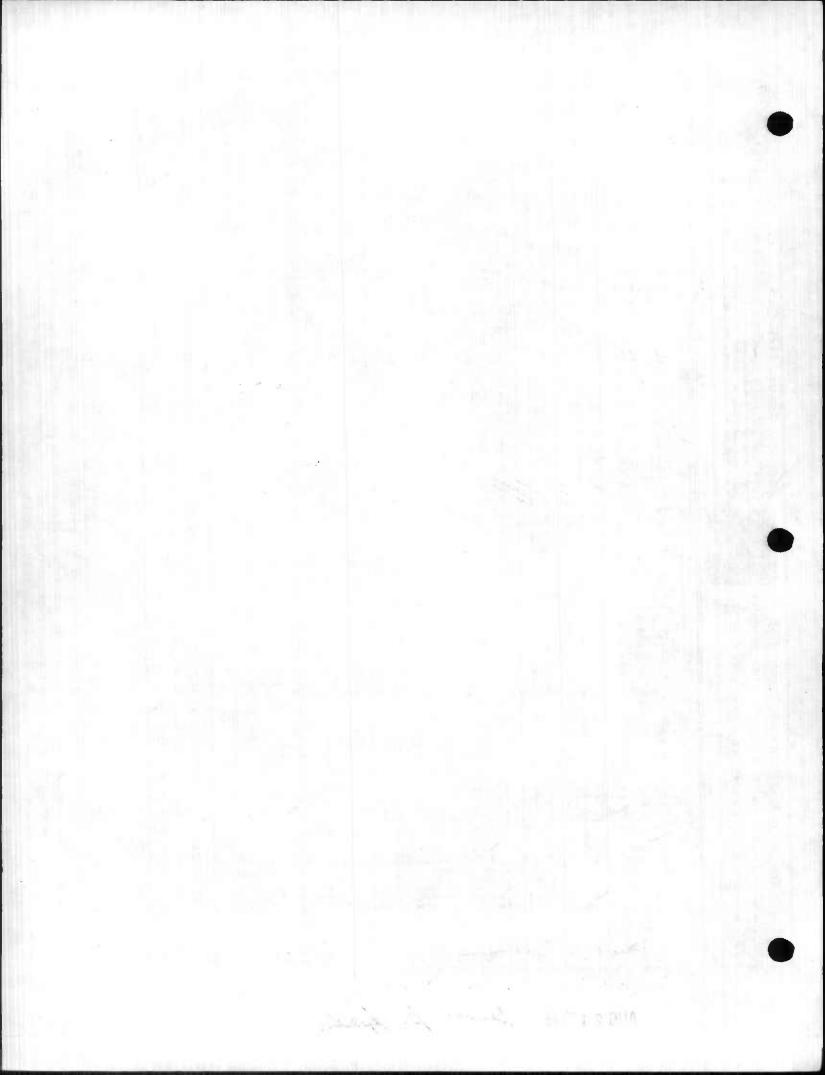
After Attanding

r death.

after death

24 hours

To the within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Month 98 **Physician** PM 2:00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Dual! **Examiner** HOMEW COI) CENTER GENESIS ELDERCAPE BALTIMORE BALTIMORE If Under 24 Hrs. 8. Data of Birth If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 22F Months Days 96 217-20-8000 Director Usuel Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nari of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits BALTMORE La Tas 2 □ No Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? th and Mental Hygiene.
7 is marked other than "natural", or flems 23a or itraumatic event, the Medical Evanther must be or BOKEL 401 2/4/2 USM Funerai 12. Wes Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 ☐ Yes _Z☐ NO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black Specify: by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) givate family Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER 4 CARS 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) WESTES mith ENMA WALKINS 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Baltinor, NunyIno 2/2/2 BUKEL Court BHNIE Doughta 401 Item 27 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any Injury or of Burial 2 Cramation 3 Removel from Stete Cemeter Towson 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility CHIP THAN -HAMMING 21. Signature of Funerel Servica Ligarian 3240 TWA Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner eas physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): 88 950 for signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 28 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? should I 24a. Was an autopsy performed? Completed After this certificate has funeral director, page 2 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 200 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Natural 5 Pending n 24 hours after death.

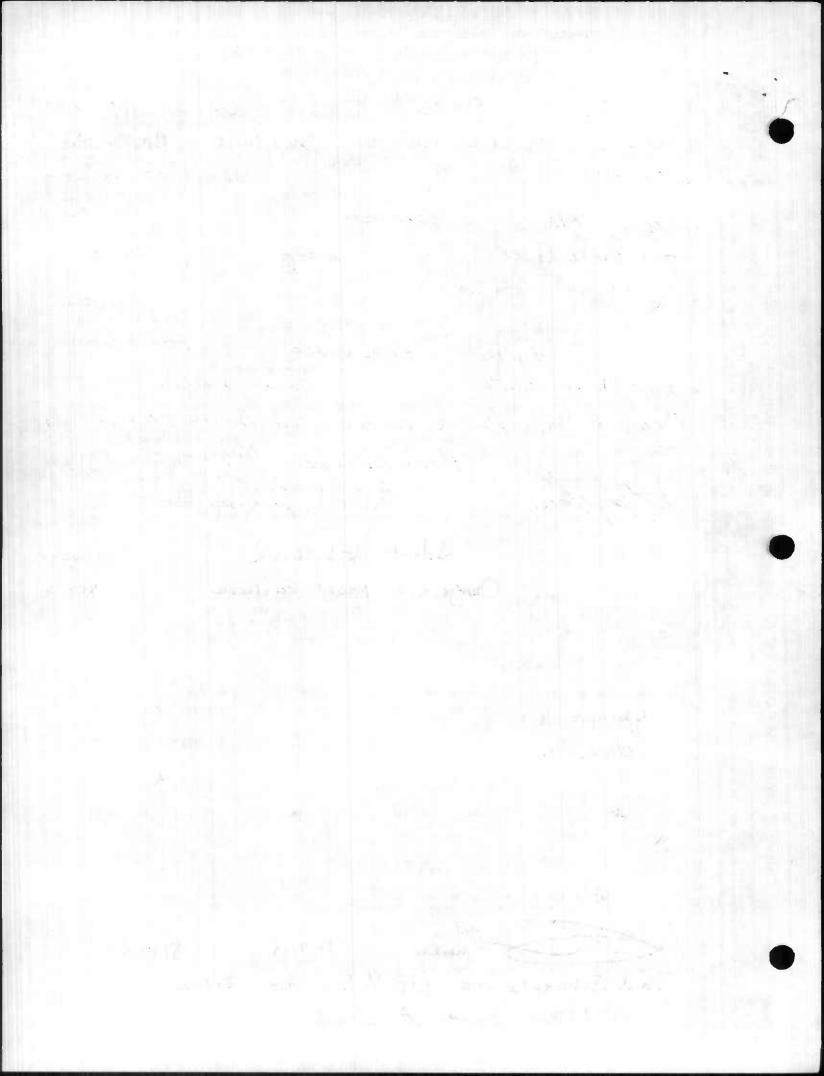
Funeral Director: After the function of the function 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Lactifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the causa(s) and mannar as stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifie edical completely (Check only one) within 2 29d. Data signad (Month, Day, Year) 29b. Signature and arts of condition Medical 29c. Licansa number Askerdiva 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 21212 M.D.

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 4 1999

32. Registrer's Signeture

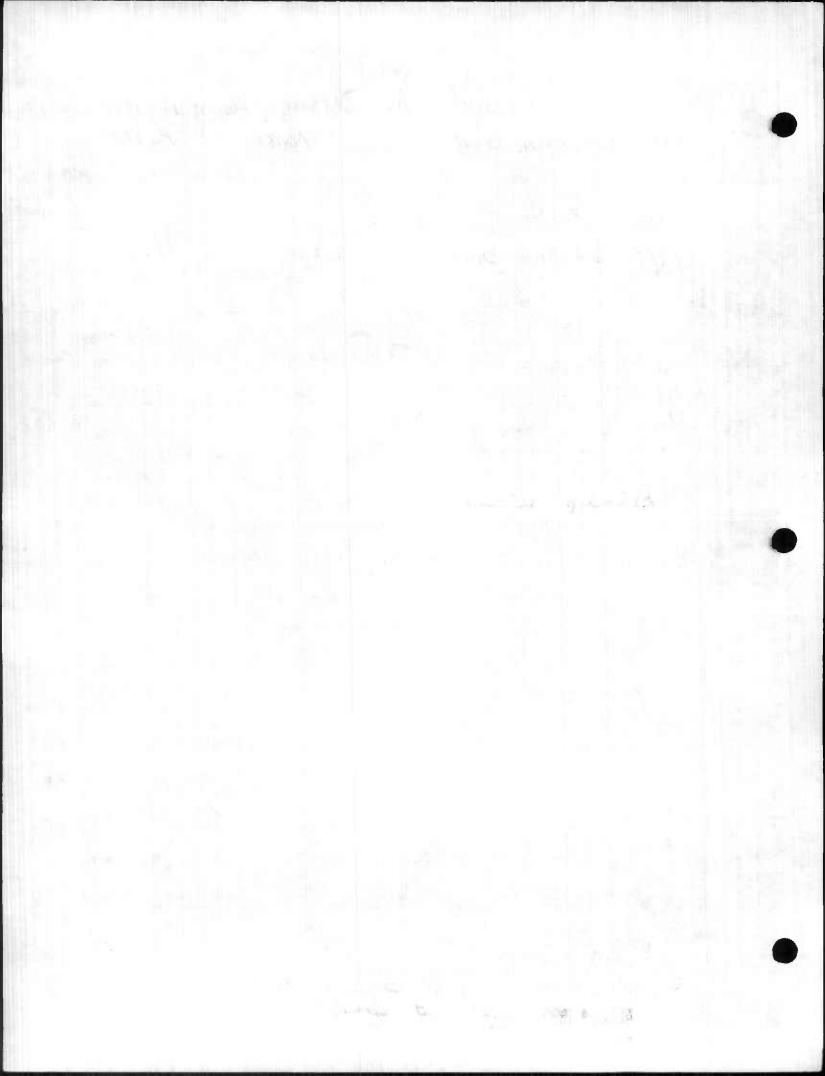


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Certifica	ate of Death	Reg	. No.	20041		
Physician /Medical	Decedent's Name (First, Middle, Last)	Howard	A	Dorsey	2. Date of Death Month August		3. Time of Death		
Examiner	4a Facility Name (If not institution, give stre 1718 G/en Kery 5. Social Security Number 6. Sex	H B/Ud 7. Age (In yrs.	last histodays) If Un	4b. City, fown, or OUS Ser 1 Year If Under 24 Hrs	Location of Death Death B. Date of Birth	Bal)	40		
Funeral Director	212-30-3446 10M Usual Residence of Decedent	20 F 66	Month		(Month, Day, Y	1932	9. Birthplace (State or Forei Country)		
28a-f show notified at	10a. State 10b. County Md Balt	0 10c. Ci	ty, Town or Location OWSON				10d. Inside City Limi 1 ☐ Yes 2		
At, or flems 23s or Examiner must be by Funeral Dir	19 Glen Ker	th Blud		ZID Code 21286		Citizen of Wh	·A		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (specify Cuban, Mexican, Puer 2 DANO Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. Black		
Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of life. DO NO	6a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver					
BeC	17. Father's Name (First, Middle, Last)				eme (First, Middle, Ma	iden Sumeme)			
2	Herman Don	sey				rg4e			
	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Addre	ess (Street and Number or R	iural Route Number, C	City or Town, S			
other traumatic event, the Manager of the Manager o	20a. Method of Disposition	200	Place of Disposition (/	leme of	Date 20	c. Location - C	Z1Z3		
	1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State / /	ametery, cremetory of	FOCENT 1/et	8/25/99 C	Wings	Mills Md		
9000	21. Signature of Funeral Service Licensee	vanes	Yar Yar	and Address of Facility F. H. W. 300 Was	est bash su	enne	Balto, ud		
edical Examiner									
an/Medical	thet initiated events resulting in death) Last								
/sick	Part II. Other eignificant conditions contrib	uting to death but not res	sulting in the underlyin	g cause given in Part I.	23b. Did tobe	3b. Did tobacco use contribute to the cause of death			
by Physician/M					1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Ø Unkn				
Completed					24a. Was an a performe	autopsy d?	24b. Were sutopsy finding available prior to completion of cause of death?		
Сошр					1□ Yes	2 No	1 ☐ Yes 2 No		
To Be Com	25. Was case referred to medical examiner?	pitel:	ER/Outpatient 3	Other	Home 5 Desiden	o a Cothar	(Snaoki)		
75		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No	g Home 5 PResidence 8 Other (Specify) 28d. Describe how injury occurred				
Certification:	2 Cuiside 6 Could not be	28e. Place of Injury - At h building, etc. (Special		ory, office	28f. Location (Stree City or Town,		or Rural Route Number,		
Medical Certification:	29a. Certifier Check only one) Certifying Physicial Certifying Physical Certifying Physicial Certifying Physical Certifying Physical Certifying Physical Certifying Physicial Certifying Physicial Certifying Physical Certifying Physical Certifying Physical Certif	en: To the best of my kno On the basis of examina and manner stated.	owledge, deeth occurration and/or investigation	ed at the time, date and place on, in my opinion, deeth occ	e, and due to the causured at the time, date	se(s) and mani e end place, an	ner as stated. d due to the cause(s)		
×	29b. Signature and title of certifier			9c. License number	290	. Date signed	(Month, Day, Year)		
	30. Name and address of passon who comp	leted churs of death (Iter	n 23a) (Type Print)	P11749	7	8 24	99		
J	Phot Cumm	. 11	VA Hos	ertal Ra	to more	2	4 34		
State	31. Date filed (Month, Day, Year)	32. Flegistrar's Signi	ature L. Lo	uls					

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

			College of Maryland / De	Certificate of Dea		Reg. No.	00000				
	Physician	1. Decedant's Nema (First, Middla, Last)	EORGE	ENGLI:	2. Data of De Month	Day Yaar	3. Tima of Death				
	/Medica Examine	An English bloom (Manakinating at a st			y, Town, or Location of Deat		/				
		GOOD SAMARITE	AN HOSPITAL	B	ALTIMORE	BALTIMO	RE CITY				
	Funeral Director		M 2 F 40 Yrs. last birthd	Months Days Ho	nder 24 Hrs. 8. Data of Bir (Month, Da January		thplaca (Stata or Foreign ountry) rgia				
	yland	Usual Rasidence of Decedent 10a. Stata 10b. County	10c. City, Town of	r Location			10d. Inside City Limits				
	Ba-fat	Maryland N/A		XX							
	with the Me or 28a-fe	10e. Street and Number	lav	10f. Zip Code	1	10g. Citizen of What Co	ountry?				
	after death with the Meryland or Hems 23s or 28s-f show crimer must be notified at Figures Director	5315 St Albans M	2 Was Decedent Ever in U.S. 1	21212 3. Was Decedent of Hispani	ic Origin? (Specify Yas or No						
020	al, or he	3 □ Widowed 🏋 Divorced	Armed Forces? 1 Yas 2 No M Yas, Giva Year or Detes:		oxican, Puarto Rican, atc.)	Black, Whit	white				
21215-0020	c ' # -	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation 16a. De (G (G (G)))	ocedent's Usual Occupation iva kind of work done during a. DO NOT use retired) Stock Broker	most of working	16b. Kind of Businass					
	be filed with tal Hygiene. d other than event, the land	17. Fathar's Nama (First, Middla, Last)									
yiar	2 should be filed within and Mental Hygiene. a marked other than aumatic event, the Ma	Peter George En	glish	(Charlotte McG	innis					
Maryiand	0 0 0 0	19a. Informant's Name/Ralationship (Type Charlotte McG. Eng	er, City or Town, Stata, .								
re,	of Heaith of Heaith I ham 27 r other tr	20a. Mathod of Disposition	20b. Place of Di	sposition (Nama of crematory or other placa)	Data	20c. Location - City or					
imo	Pa Pa	XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Othar (Specify)	moval from Stata	ds Churchyard	8/26/99	Wayne Penn	Pennsylvania				
Baltimore	permit. Pages 1 and Department of Health Important: If Itam 27 any Injury or other tr pncs.	21, Signetura of Funaral Sarvice Licensee (22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212									
		23a. Part1. Enter the diseasa, or complice shock, or haart tailura. List only one	ations that caused tha death. Do not a cause on each line.	entar tha mode of dying, suc	th as cardiac or respiratory a	rast,	Approximate Interval Between				
	Physician /Medical Examiner	Immediata Cause (Final diseasa or condition rasulting in death) a.	Hepatic	encepha	lopathy		2 weeks				
	je je		Endstage	sequence of):	150050						
	icate be executed physician and s the burial-transit	Sequentially list conditions, if any, laading to immediate	Dua to (or as a con	sequence of):	1124004	4 ,					
68760,	sician burial		Alcohul-In		patic cir	rhuis	1				
Box	death certified e ettending e ettending ed for use a sician/Ma	d.					1				
P.O.	that the death certified by the ettending detached for use a Physician/M.	Part II. Other algnificant conditions contr	ibuting to death but not resulting in th	e underlying causa given in I		/	a to the cause of death?				
	signed b	Halle r	zenal tailui	7.6	10	Yes 2. No 3 P	robably 4 Unknown				
of Vital Records,	been shou	Subdural	hemorrha	ge		ermed?	Wara autopsy findings available prior to completion of cause of death?				
I Re	The law ate has page 2				10	Yas 2 No	1 Yas 2 No				
Vita	ysicien: The sector, pag director, pag	25. Was casa rafarred to medical axaminar?	spital:	Other	Placa of Death (Check only						
o	this aldi	TLI TAS ZAZINO	26a. Data of Injury 28b. Time		□ Nursing Home 5 □ Rasi 28d. Describe	dance 6 Other (Spe	ecify)				
ion	ath. r:: Afte ne fun	1 ☑Natural 5 ☐ Pending 2 ☐ Accidant investigation	(Month, Day Year) Injur	y Work? M 1 □ Yas							
Division	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (3 Suicida 6 Could not be detarmined	28a. Place of Injury - At homa, farm, building, atc. (Specify)	28f. Location (. City or Tot	Street and Number or R vn, Stata)	lural Route Number,					
	n 24 hound no 24 hound no Funer pletely fit	29a. Certifier 1 Certifying Physic (Check only one)	clan: To the best of my knowledge, da or: On the basis of examination and/or and manner stated.	eath occurred at the time, da r investigation, in my opinion	ta and place, and dua to tha , death occurred at tha tima,	cause(s) and mannar a: data and placa, and du	s stated. a to tha cause(s)				
	To the comple		, M.D.	29c. License num		29d. Data signed (Mont					
		30. Nama and addrass of person who com	plated causa of death (Item 23a) (Typ	pe, Print)	I LOCH DAVE	V RIVD R	ALTIMOPE				
	State	WILLIAM IMBEAH 31. Data filed (Month, Day, Year)	Registrer's Signature	HOPI (HL) > 0	of Codil Halaci	N	D 21239				
	State	ALIG 9 1 1999	heave 4	1 .							

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Health a Certificate of Death		rgiene Reg. No. 99 2651.3					
Dhysisian	Decedent's Nama (First, Middle, Last)	2. Date of De Month	Day Year					
Physician /Medical	THELMA MARIE EDWARDS		2, 1999 10:55 a.m.					
Examiner		wn, or Location of Deat	th 4c. County of Death					
	Eastpoint Nursing Home Balti		Baltimore					
Funeral Director	5. Social Security Number 228-16-0733 6. Sex 1 Months 1 M	24 Hrs. 8. Date of Bi (Month, Di Aug. 2	orth (Year) 9. Birthplace (State or Foreign Country) 9. Wirgunia					
P	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Insida City Limits					
A de la de l	Maryland Baltimore Baltimore		1 □ Yes 2 🕅 No					
the Mary 28a-f sh polified.	10e. Street and Number 5000 Date Street and Number 10f. Zip Code	T	10g. Citizen of What Country?					
Elso ell								
death me 23 Limitel	1936 Holborn Road 11. Merital Stafus 12. Wes Decedant Evar in U.S. 13. Was Decedent of Hispanic Original Control	gin? (Specify Yas or N	U.S.A.					
020 un after ir, or ha Examina by Fur	Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No 2 No 2 No 3 No	n, Puerto Rican, etc.)	Bleck, White, etc. Specify: White					
5-0 72 72 72 72 72 74 Bisell Bisell	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	t of working	16b. Kind of Business/Industry					
und 21215-0 be illed within 72 ho but Hygiene. d other than "return event, the Medical. Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	t or working						
d 212 Higgins Hygens and that the ball	7th grade Homemaker		Own Home					
D STORE BE		er's Neme (First, Middle	, Meiden Surneme)					
Aarylan 2 should be 3 and Mental is marked or mumatic ev	Heath M. Ogle Bess	sie Cole						
Aar 2 short saum	19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number)							
	Lois Adelung (Daughter) 1936 Holborn Road							
Or off Hear	20a. Method of Disposition 1 ⊠ Buriat 2 □ Cremetion 3 □ Ramoval from Stata	Date	20c. Location - City or Town, Stata					
Page Page Way out you	4 □ Donetion 5 □ Other (Specify) Bel Air Memorial Garde	ns 8/24/99	Bel Air, Maryland					
Baltimore, permit. Pages 1 er Department of Nea Important! It lean any Injury or other once.	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD.							
	23a. Part1. Enter the disease, as emplications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List on one cause on each line.							
/ Physician /Medical Examiner	Immediata Cause (Finel disease or condition resulting in death) a. If the solution is a consequence of its solution.	Diseau	Onset and Deeth					
K 68760, Antificate be assected ing physician end es the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b. Due to (or es a consequence of): c. Due to (or es e consequence of):							
death certific entending ped for use es	0.							
D. E	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f	. 23b. Did	tobacco usa contribute to the cause of death?					
is, P.O. Box 6 as that the death certific igned by the ettending p be detached for use es by Physician/Mer	Dehy dratim	10	Yee 2□ No 3□ Probebly 4 中 Onknown					
aw requires been s 2 should pieted			s an autopsy ormed? 24b. Were eutopsy findings available prior to completion of causa of death?					
The law ate has page 2		10	Yes 200 1 Yes 2 No					
VItal Indicate: The certificate irector, pag	25. Wes case referred to medical axaminer?	of Deeth (Check only	one)					
- K - 5	Hospitel:	ursing Home 5 Res	idence 6 Other (Specify)					
After fund	27. Manner of Death 1 Neture 5 Pending (Month, Dey Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Accident investigation M 1 Yes 2		how injury occurred					
Division of the or Attending P as a flar death. In Director: After the funeritied in by the funeritied in certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, streef, factory, office building, etc. (Specify)		(Street end Number or Rural Route Number, wn, Stete)					
Division To the Hospital or Attendible Wilhin 24 hours eiter death To the Funerel Director: completely filled in by the Medical Certificat	29e. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date en considerable (Check only one) 1 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deed and manner stated.							
M M	29b. Signature and little of confligs.		29d. Date signed (Month, Dey, Year)					
	N 1115	0	8/23/995					
		IE, BALTI	8/23/pas 0 MD 21224					
State Registrar	31. Date filed (Month, Day, Year) AUG 2 4 1999 32. Registrer's Signature							

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ORIGINAL

ALGERTAL THE EXPLANA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physicia	an	1. Decedent's Name (First, Midd		tanton	Fyans			2. Date of De	Day	Veer	3. Time of Deeth 3:08 AM	
/Medic	al	4e. Facility Neme (If not institutio			LVans	4	b City Town or	Au Location of Deat	gust 20, 199		3.00 AIVI	
Examin	er	To Thomas (Tribut Motivation	5343 Heather					cott City	40. County	Howa	ard	
Funeral Director		5. Social Security Number 195-4 295396-8390	6. Sex 10 M 2□ F	Age (In yrs. I	Mor	Inder 1 Year oths Days	If Under 24 Hrs Hours Min	(Month, Da	th ly, _{Year)} er 15, 1956	9. Birthplac Country Pen	e (State or Foreig nsylvania	
oe filed within 72 hours e tal Hygiene. I other than "natural", o went, the Madical Exan	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location					10d	Inside City Limit	
	stor	Maryland	Howard			EI	licott City				1 □ Yes 2 N	
	Funeral Director	10e. Street and Number 10f. Zip Code 21043							10g. Citizen of V	Vhet Country U.S.A.		
	by Funer	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Ves Give	es? No	If Yes,	ecedent of Hi specify Cube es 2 No	ispanic Origin? (S n, Mexicen, Puer Specify:	Specify Yes or No to Ricen, etc.)		e - Americen k, White, etc		
	Be Completed		t's Education st grade completed) College (1-	4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Developement			- 68	16b. Kind of Business/Industry Computer		•	
	To Be C	17. Fether's Name (First, Middle, Last) George A. Evans							e (First, Middle, Maiden Surname) Agnes Ann Schirm			
z/ IS IImi		19a. Informant's Name/Relations Mrs. Jennifer J. Ev		/ife					al Route Number, City or Town, State, Zip Code) tt City, Maryland 21043			
Department of Hear Sport of Hear Sport of Hear Sport of Hear Sany Injury or other pages.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (S			ace of Disposition emetery, crematory Metro	(Name of or other place Cremato		Date 08/20/99	20c. Location - Balti	City or Town		
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043										
ficate be	8	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	Due to (or	as a consequence	of):				0	YVS -	
	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.						23b. Did	tobacco use con	ntribute to th	ne cause of death	
the at	=								Yes 2 No	3 Probat	oly 4 Unknow	
igned by the be detached	þ									performed? available pr		
igned by the be detached	þ							24a. Was	an autopsy ormed?	comp	letion of ceuse	
hes been signed by the je 2 should be detached	Completed by	25. Was case referred to medica					26 Place of Da	perfo	Yes 2 No	comp	ible prior to iletion of ceuse ath?	
ther this centificate hes been signed by the uneral director, page 2 should be detached	To Be Completed by	25. Was cese referred to medica examiner? 1 Yes No 27. Manner of Death Naturat 5 Pendir	Hospital: 1 ☐ In 28a. Date of (Month)		ER/Outpatient 3D 28b. Time of Injury M	DOA Oth	er: 4□ Nursing I	ath (Check only)	Yes 2 No	avaite comp of det	able prior to eletion of ceuse ath?	
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ne Funerel Director: Atler this centificate hes been signed by the pletely filled in by the funeral director, page 2 should be detached.	ledical Certification: To Be Completed by	examiner? 1 Yes No 27. Manner of Death Naturat 5 Pendir investi 3 Suicide 6 Could 4 Homicide 29a. Certifler (Check only) 2 Medical	Hospital: 1 In Inggraded I	Injury Day Year) If Injury - At hog, etc. (Specify est of my know is of examination stated.	28b. Time of Injury M me, farm, street, fa) viedge, death occu on and/or investige	28c. Injung Word 1 Cotory, office rred at the timation, in my of	er: 4 Nursing I	ath (Check only of the characteristics) ath (Check only of the characteristics) 28d. Describe 28f. Location (City or To:	Yes 2 No one) dence 6 □Othe how Injury occurr Street and Numb wn, State) cause(s) and ma	er (Specify) er or Rural F	ible prior to leletion of ceuse ath? Yes No Route Number, ed. le cause(s)	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme /First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Indreh pm 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Funder 24 Hrs. 8. Date o HOMEWOOD Z7UD N CHARLES
Sex. 7. Age (In yrs. lest birthday) If Under 1 Yeer FUTURFCARE 6. Sex 10 M 2□ F 8. Date of Birth (Month, Dey, Birthplace (State or Fdreign Country)
 VA . 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Hours 224-28-0462 Usuel Residence of Decedent Yrs 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/a BALTIMORE 1 TYes 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21239 USA 5803 LEITHWALK 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑XYes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yea or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11. Meritel Stetus NNever Merried 2 Merried Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) -0-CONSTRUCTION -8-TRUCK DRIVER 17. Fether'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) OSWALD B. FINNEY PEARL PRIITT 19e, Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5803 LEITHWALK BALTIMORE, MARYLAND 21239 SHEILA OKPALA(DAUGHTER) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) GARRISON FOREST VETERANS 8-27-99 OWINGS MILLS, MARYLAND 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funerel Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 clor 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Onset end Death immediate Cause (Finel END - STAGE RENAL DISEASE

Due to (or es a consequence of): Unknown disease or condition resulting in deeth) DIABETE 10-15 YEARS MELLITU Due to (or es e consequence of): Due to (or es e consequence of) Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Yes

Physician /Medical Examiner

physician end the burial-transit

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signed by t

peen

After this certificate

funeral

Attending Physician:

Hospital or Attending 24 hours after death. Funeral Director: After To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu à

Completed

Be

2

Certification:

Medical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Ď

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after deeth w Department of Heelth and Mental Hygiene. Important: If frem 27 is marked other than "natural" and injury or other traumatic average.

with the Meryland

Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Physician/Medical

ESSENTIAL HYPERTENSION

CARCINOMA OF PROSTATE

1 Yes 2 No 27. Menner of Death 5 Pending Investigation 1 Neture

2 Accident 3 Suicide 6 Could not be 4 Homicide

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the cause(s) end menner steted. 29b. Signeture end title of cartifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

D18368

Ave, Suite 308. Balto. Md2/229 Komal K. Dang M.D., 3455, Wilkens

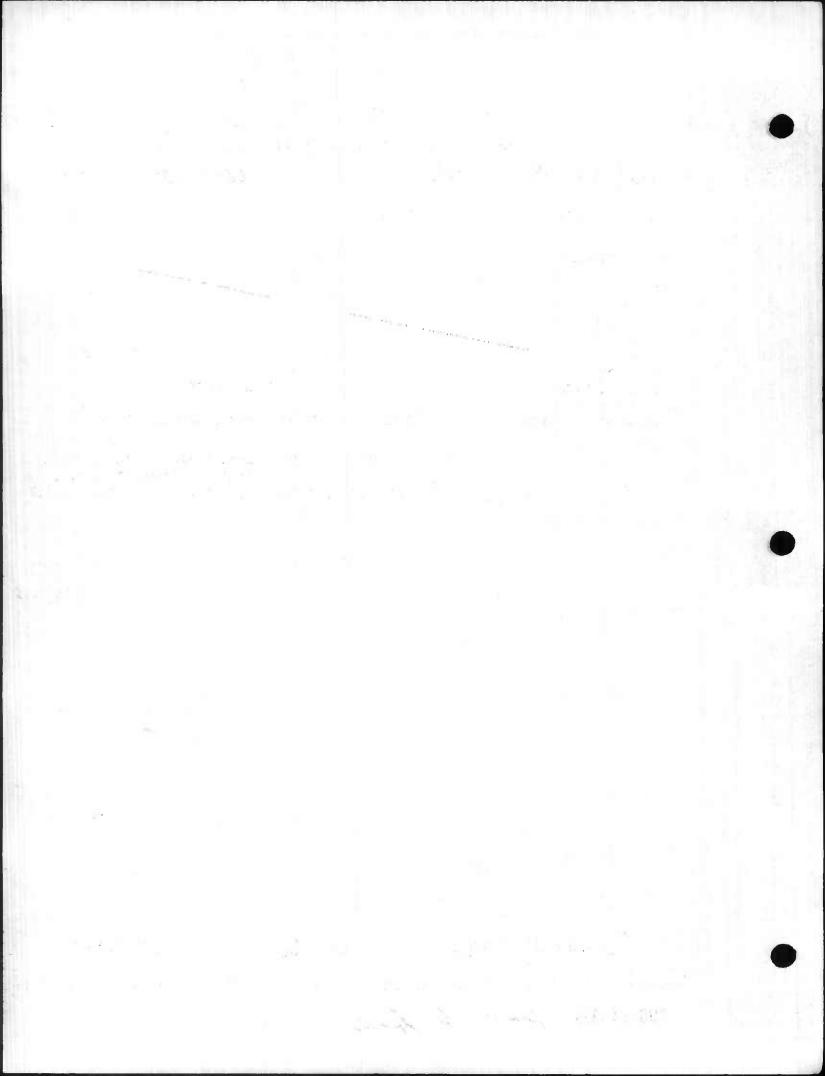
31. Dete filed (Month, Day, Year) State

29e. Certifier

AUG 2 4 1999



Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death AVGUST 1:05 Am FreemAN **3**3 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A

Funeral Director

the Maryland

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Funeral

with death filed within 72 hours after Pages 1 and 2 should be filled within 1991 of Health and Mental Hygiene.
Int: If Item 27 Is marked other than other 1 20 Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

burial-transit and physician Physician/Medical the usa as 0 ed by th signed I by Completed peen page 2 certificate director 86 2 Certification:

requires that the death certificate be axecuted Attending Physician: this funaral After re Hospital or Attention 24 hours after death. within 2 To the

Division of Vital Records, P.O. Box 68760

Physician /Medical 4a Facility Nama (If not institution, giva street and number) **Examiner** BON SECOUR HOSPITAL If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) Days Months Hours 1∭ M 2□ F 74 Yrs. 216-52-4043 3 - 7 - 25MD. Usual Rasidance of Dacedani 10a, Stata 10c, City, Town or Location 10b. County 10d. Inside City Limits MD. N/A BALTIMORE 1 N Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21223 2505 EDMONDSON AVE. USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Å Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: Specify: BLACK þ 3 ☐ Widowad 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 18a. Decedant's Usual Occupation 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) -8--0-LABORER CONSTRUCTION 17 Fathar's Nama (First Middle Last) 18 Mother's Nama (First, Middla, Maidan Surnama) Be UNKNOWN UNKNOWN 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) GOLDIE PARKER (FRIEND) 2505 EDMONDSON AVE. BALTIMORE, MARYLAND 21223 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata cematary, cramatory or other place) 1 ☐ Burial 2XI Cramation 3 ☐ Ramoval from Stata METRO CREMATORY 4 Donation 5 Othar (Specify) 8-26-99 BALTIMORE, MARYLAND 21. Signature of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Vac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvat Between Onsat and Death tmmadiata Causa (Final disaasa or condition resulting in death) lo Examiner Dua to (or as a consequance of): Dua to (or as a consequanca of)

Sequentially list conditions, if any, leading to Immadiata causa. Enter Undarfying Causa (Disease or Injury that Initiated avants rasulting in death) Last

Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatiant

Data of Injury (Month, Day Year)

1 ☐ Yee 2 ☐ No 3 ☐ Probably 24a. Was an autopsy

24b. Wara autopsy findings available prior to complation of causa of death?

1 Yas No

4 Unknown

26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify)

23b. Did tobacco use contribute to the cause of death?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier

25. Was casa referred to medical

1 Yas 2 No

27. Manpar of Death

1 Natural 2 Accidant

3 Sulcida

4 Homicide

to Certifying Phyelcian: To the best of my knowledge, daath occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29c. Licansa number

28c. Injury at Work?

1 ☐ Yes

2 No

29b. Signatura and titla of certifian

5 Panding invastigation

6 Could not be

29d. Data signed (Month, Day, Year)

death (Itam 23a) (Type, Print)

Baltinone, ind 21223 Hospital 32. Registrar's Signatura

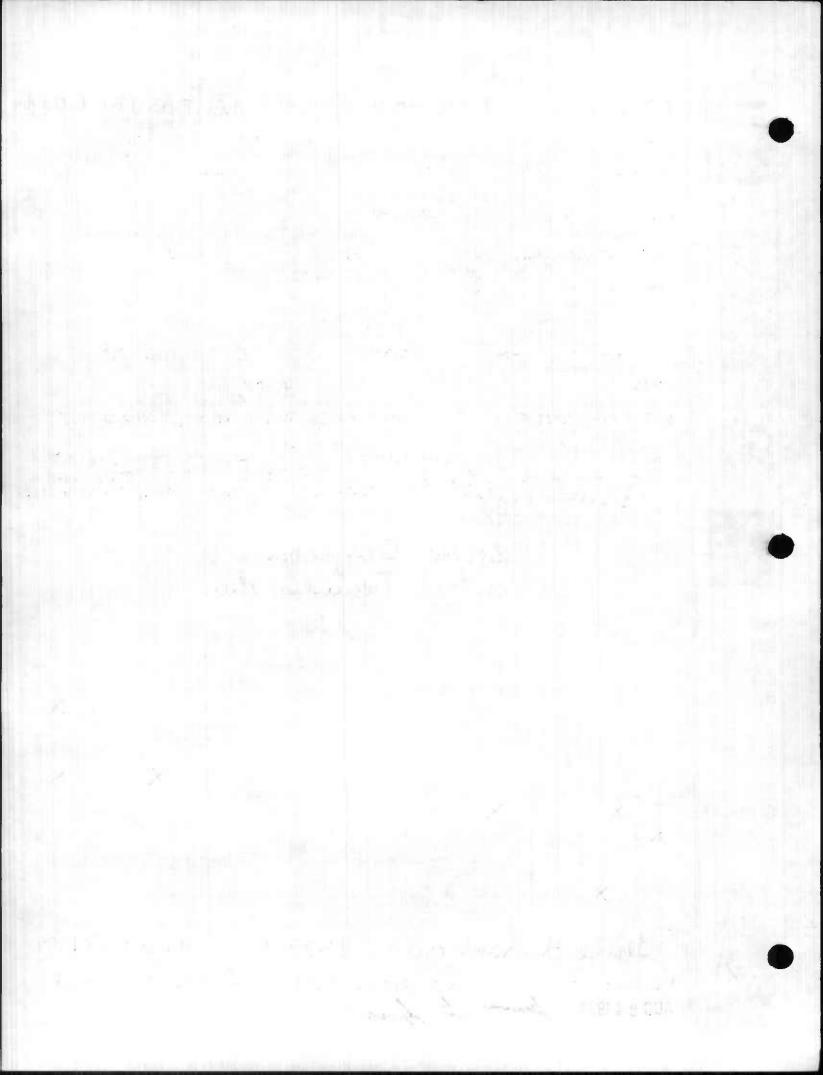
2 ER/Outpatient 3 DOA

28b. Tima of

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

State Registrar

edical



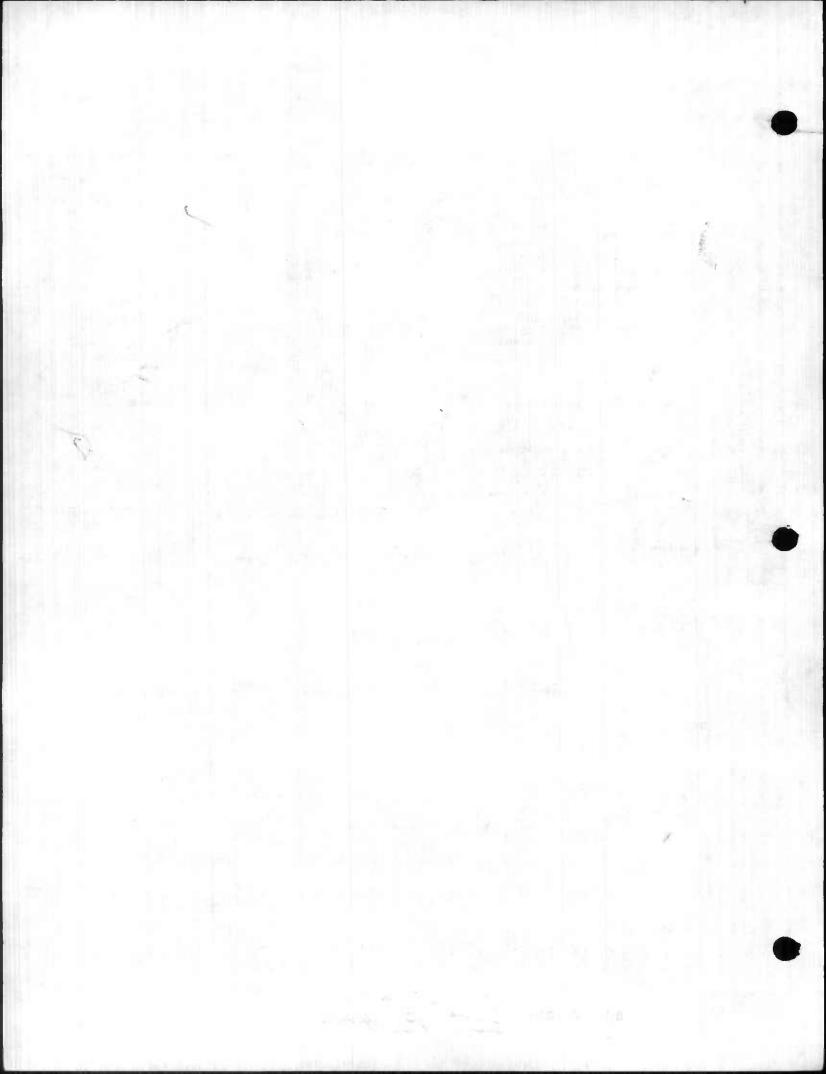
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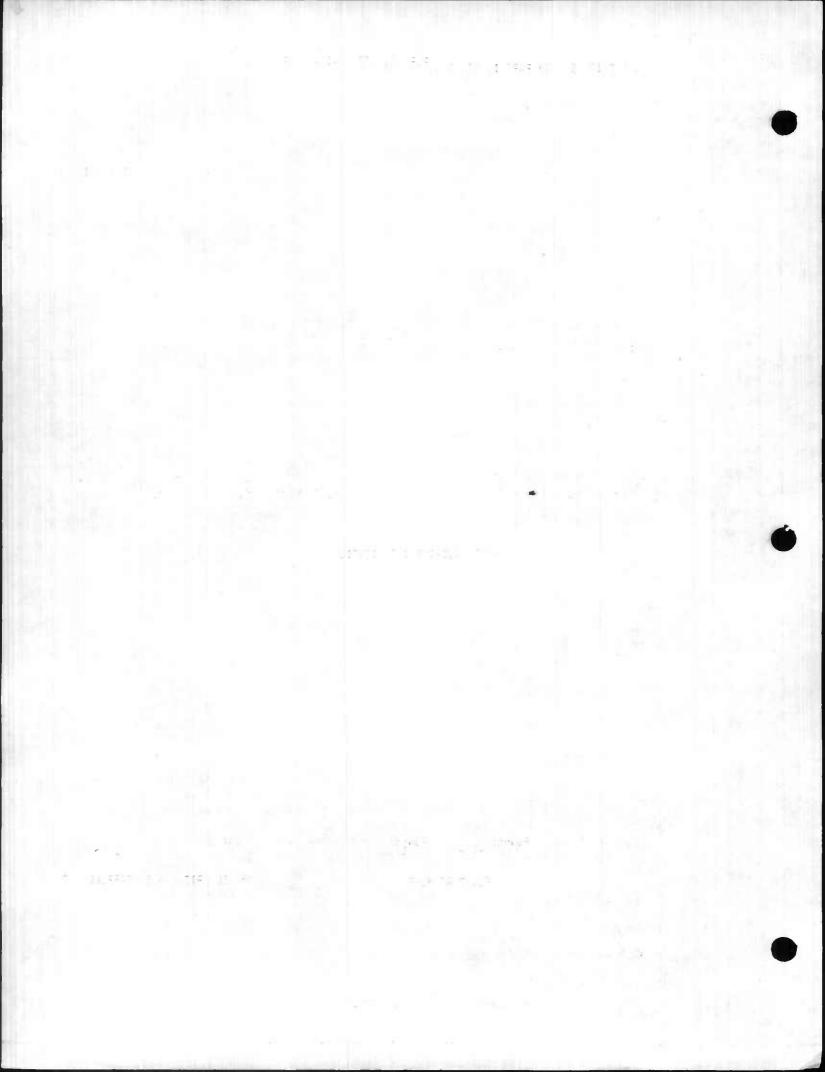
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 08-19-99 Day **Physician** 5:20p.M. HUTZLER FREEMAN /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5918 LEEWOOD AVENUE CATONSVILLE BALTO. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 01-15-30 Birthplace (Stata or Foraign Country)
 MD 5. Social Security Number 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 213 26 9543 69 Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo MD BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 5918 LEEWOOD AVENUE 21228 USA 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 2 Yes 2 No
If Yes, Give
Year or Dates: Black, White, atc. Pages 1 and 2 should be illed within 72 hours after ment of Health and Mentel Hygieno.
ant: If item 72 is merked other than "natural; or the sury or other transmitte event, the Medical Examining my or other transmitte event, the Medical Examining. 1 Never Married 2 Married Specify: BLACK Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) CHEMIST PAINT CO. 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Nama (First, Middle, Last) WILLIAM FREEMAN ESTELLA HIGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 LEEWOOD AVENUE CATONSVILLE, MD. 21228 JOAN FREEMAN/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Removat from State Department of Important: If any injury or ance. WESTERN STAR CEM. 8/26/99 4 □ Degation 5 □ Other (Specify) BALTIMORE, MD. 21. Signature of Funeral Service Licenses 22, Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final SixMonths Adenocarcinoma disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): and Box 68760. ettending physician Due to (or as a consequence of): USB as signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vitai Records, P.O. 1 Yes 2□ No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of causa of death? has page 2 2 NNo 1□ Yes 1 ☐ Yas 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Naturat i efter death.
I Director: Aff 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital within 24 hours o To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifier completely (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) folla Catrafra Bult. MD 21229 7. deal 31. Agues 1 nes 1103 31. Date filed (Month, Day, Year) State AUG24 Registrar

DHMH 16 Ray 6/95





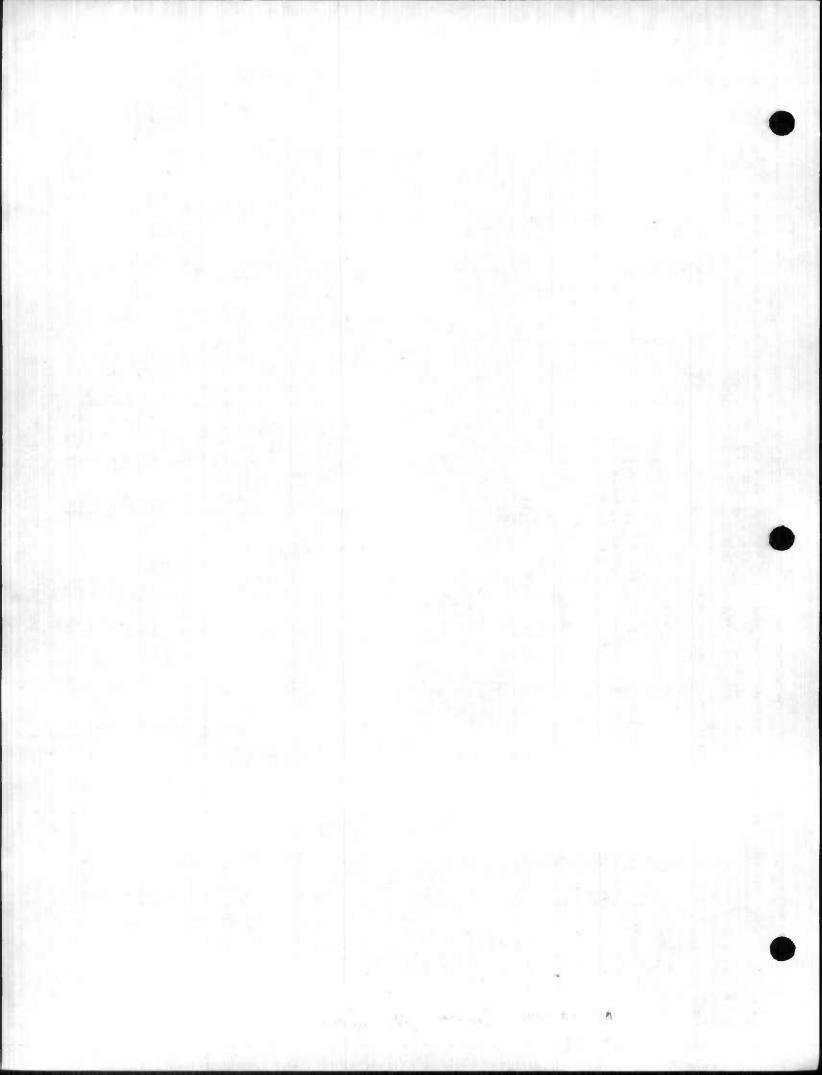
State of Maryland / Department of Health and Mental Hygiene

				,	Certi	ficate of	Death	R	eg. No.	2654	9	
Physician		1. Decedent's Name (First, Middle, L	est)					2. Date of Deal		3. Time	of Death	
Physic /Medi		Chester Miller	Grove						15, 1999		0 a.m.	
Exami		4e Facility Neme (If not Institution, gi	ve street and number)				4b. City, Town, or	Location of Death	4c. County of			
		Morningside Hou		el .			Laurel			e George		
Funeral Director		3/0-10-042/	Sex 7. Ag	91		If Under 1 Year Months Deys			Year) 1908 V	B. Birthplace (State Country) Vashingto	or Foreign	
pue *		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Toy	wn or Locat	tion				10d. Inside	City Limits	
Aaryle Aaryle of	MD Prince	Coorgo		sville						s 2 No		
28 the p	Tect	10e. Street and Number	George	Delts		10f. Zip Code		1	10g. Citizen of What Country?			
3a or	0	4720 Naples Ave	7110			20705			USA			
death	Funeral Director	11. Marital Stetus	12. Was Decedent		13. Wa		Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No-	14. Race	American Indien,		
21215-0020 d within 72 hours efter death with the Marylend piene. r than "natural", or flama 23a or 28a-f ahow ma Medical Examinar must be profitted at	þ	1 Never Merried 2 Married 3 Widowed 4 Divorced	If Yas Giva**			es, specify Cult Yes 2X No		to Hican, etc.)	Specify:	White, etc. White		
5-0 72 ho	Be Completed	15. Decedent's E	ducation	168	Deceden	t's Usuat Occu	pation	urkina	16b. Kind of Bus	ness/industry		
	ple	Elementary/Secondary (0-12)	College (1-4or !	5+)	(Give kind of work done during most of working life. DO NOT use retired)							
	S	12	I	river	c				ransport	ation		
aryland 2 should be filed v and Mental Hygie a marked other t umartic event, m	Be	17. Fether's Neme (First, Middle, Las		18. Mother's Neme (First, Middle, Maiden Sumame)								
arylan should be nd Mental marked c	2	John H. Grove				Sadie 1						
6 0 4 4 4		19a. Informant's Name/Reletionship		19				ural Route Number				
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Pages nent of l mt: If the		XXBuriel 2 □Cremation 3 [cemete	ery, cremat	ory or other pla						
altimore, mit. Pages t ar partment of Hea portant: If them 2 y Injury or other		4 Donation 5 Other (Speci		Ft. I		ln Ceme		8/18/99	Brentwo	od, Mary	land	
Department on the property of		21. Signature of Funeral Service Lice	77/)			lame and Addr Fleck F	ess of Facility uneral Ho	ome. Inc.				
		23a. Penti. Enjer in e disease, or con	Malke)					Laurel,	Maryland	20707	
		23a. Pert1. Englished disease, of conshock, of hand failure. List only	plications that caused one cause on each li	d the deeth. Do ne.	not enter t	the mode of dy	Ing, such es cardia	c or respiretory arr	est,	Approxim Interval B	etween	
Physician /Medical		Immediate Cons (Final)				1	T A.					
Examiner		Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEAM FAILURE								276A	RS	
	5			Due to (or as a						0 46		
pet usit	ulu		b. COR	DNARY		KT FUX	PILEASE			12 45	MILS_	
and and	X	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury c. HYPER CHOLES TEROLEMINE.								1		
68 / 60, ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events	CEROL	OLEMA 27EONS								
o phy as the	B	resulting in death) Last Due to (or as a consequenca of):										
BOX eath certi	2		d									
d for	cla	Pert II. Other significant conditions	ut not resulting	in the unde	arlying cause g	iven in Part I	23b. Dtd to	23b. Did tobacco use contributs to the cause of death				
of by the	Physician/N		-			Work with Care to		1 Yes 2 No 3 Probably 4 □				
s tha	by	HISTORY	PROST,	FLE CX	NCA							
RECOIDS, P.O. BOX 68/60, he lew requires that the death certificate be executed has been signed by the attending physician and ge 2 should be deteched for use as the burial-transit	Completed							24a. Was a perform	n autopsy med?	24b. Were autopsy available prio completion of of death?	rto	
The le	E							1 🗆 Ye	es 2 DNo	1 ☐ Yes 2		
	BeC	25. Was case referred to medical					26 Place of De	ath (Check only on		10100 20	3110	
Of VICE Physician: this certific ral director,	0	examiner?	Hospitel:	ent 2 ER/O	utpatient	3 DOA O	hor	Home 5 Reside		(Specify) ACCL	STED	
Phys eral di	ı.	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	28c. Inju		_	ow injury occurre			
ath. After a funder	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigetic	(Month, Da	y Year)	Injury		Yes 2 No			MV I	N G-	
or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace of inj	ury - At home, f	arm, street	, factory, office		28f. Location (St City or Town	reet and Number	or Rural Route Nu	mber,	
D Patro	Cer	4 Distriction	building, et	с. (эрөспу)				City or Town	i, Siale/			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and menner ste	examinetion at	e, death oc nd/or invest	courred at the ti	ime, date and plec opinion, deeth occ	e, end due to the courred et the time, do	ause(s) and man ate and plece, ar	ner as stated d due to the cause	n(s)	
Withir To th	Σ	29b. Signature and title of confider	D -	_		29c, Licen	se number	2	9d. Date signed	(Month, Day, Year)		
1	-	1/100	My			1	-25914		8/	6/99		
0	ŀ	30. Name and address of person who	completed cause of d	eeth (Item 23a)		nt)			7 '	-		
V		n (7.	Ther, MD.	122			CHORD DI	L SILVER	SPRING.	RD 20	504	
Sta	ite	31. Date filed (Month, Day, Year)	12	er's Signeture					(
Registr	ar	ALIC 9 A	1000		4	/						

DHMH 16 Rev 6/95

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ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Ard Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month GOUKER MARJORIE August 20, 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth BAHMARE, VITY If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) HOPKINS Hosp ItAL Tohns If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Days Months 1 M 2 F Yrs. 215-18-5483 APRIL 24, 1921 MD Usuel Residence of Decedent 10a. Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No LUTHERVILLE MD BALTIMORE 10o. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 14. Race - American Indian, Bleck, White, etc. 10509 SAMONA ROAD 21030 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Yeer or Detes: WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) STATE OF Elementery/Secondery (0-12) College (1-4or 5+) CLERICAL 12 MARY LAND 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) HAYDEN ELMORE HARGEST ELVRIDGE 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SPOUSE 10509 , MD. 21030 SAMONA RD. LUTHERVILLE WILLIAM S. GOUKEP 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete NG 24 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) DULANG VALLEY MEH GOWS 1999 THOWINM 21 Signature of Funeral Service Licenses 22. Name end Address of Facility EVANS FUNERAL CHAPEL Laura Christine Hardesty 21093 2315 YORK PD. THONIUM MA 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Immedieta Cause (Finai GASTROINTESTINAL BLEEDING FIVE DAYS disease or condition resulting in death) Due to (or es e consequence of): END LIVER DISEASE MONTHS STAGE Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): YEARS AUTOIMMUNE HEPATITIS Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

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Funeral

Director

Show

r than "natural", or Nama 23a or 28a-f show

deeth with the Meryland

filed within 72 hours efter

Peges 1 and 2 should be nent of Heelth and Mentel

tor other traum

Department of Important: If any Injury or DOCE.

Baltimore, Maryland 21215-0020

physicien and the burial-transit that the death certificate be executed Box 68760 980 P.O. Division of Vital Records, The or Attending Physician: this hours after death.

Physician/Medical

þ

Completed

Be

edical Certification: To

25. Was case referred to medical examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 20, 1999

State Registrar

filled in

Hospital 24 hours

To the Hosp within 24 ho To the Fune completely f

31. Dete filed (Month, Day, Year) AUG 2 4 1999

29b. Signature end little of certifier

m do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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DHMH 16 Ray 6/95

A SAME SEE BARRY the second of th SECRETARY PARTY SEATON Jen H

P S Completed page 2 has certificate Certification: To Be this uneral Aftert death. the

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Records,

of Vital

Division

Attanding Physician:

ò

within 24 hours after deat To the Funeral Director:

2

filled in

pletely

edical

CARCINOMA OF KIDNEY (PER HISTORY)

28a. Dete of Injury (Month, Dey Year)

23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown

3. Time of Death

10d. Inside City Limits Yes 2 No

> Approximate Interval Between Onset and Death

12:57 P.M.

24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed?

August 18, 1999

1'XYes 2□ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) 28d. Describe how Injury occurred

Pes 2 No

1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signatute and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

28c. Injury at Work?

Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year)

25. Was case referred to medical examiner?

NOXYes 2 No

27. Manner of Deeth

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

1 Netural

AUG 2 4 1958

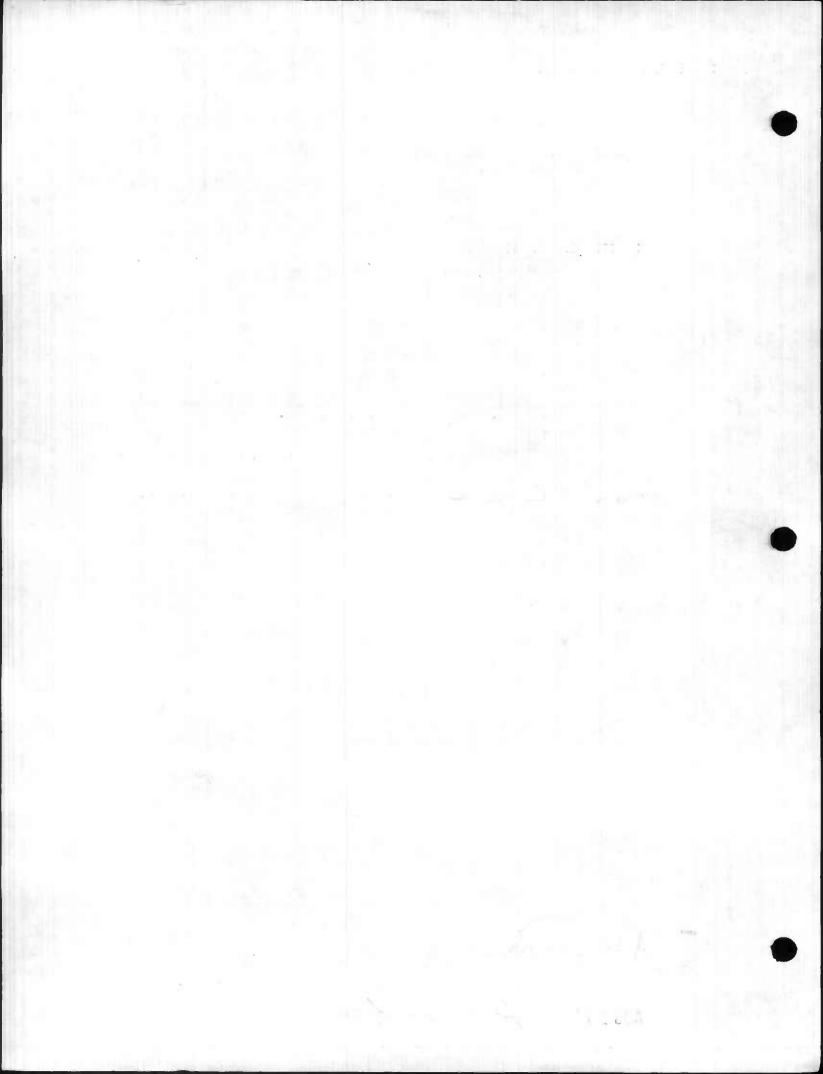
5 Pending Investigation

6 Could not be determined

Margarita Korell M.D. 32 Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edward E. August 23, 1999 Gardner 7:20 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Gilchrist Hospice Center Towson If Under 24 Hrs Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F Months Hours 216-09-6010 Yrs **Director** 81 June 12, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d, Inside City Limits 1 Yes 2 □ No Director Maryland N/A Baltimore 28s-7 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Barns 23a 4401 Roland Avenue Unit 108 21210 USA 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married XX Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) of Hygiene. College (1-4or 5+) Proprietor 20 Merchant Sales 10 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Irving Gardner marked Carmen Taylor 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hom 27 4401 Roland Avenue Unit 108 Baltimore, Maryland Annie R. Gardner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If h any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial 8/25/99 Cockeysville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Juneral Service Licens 22. Name end Address of Facility Burgee-Henss-Seitz, Inc. 23a. Part. Entry this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or their failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** WHONN SMALL CELL CARRINOMA OF THE LUNG /Medical Immediete Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): Physician/Medical that initiated events resulting In death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO SPICE C 27, Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification:

8 of Vital Records, Division

signed by this After ! death.

Pages 1

The law requires that the death certificate or Attanding within 24 hours efter deat To the Funeral Director: completely filled in by the

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier MD

5 Pending investigation

6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who dompleted cause of death (Item 23a) (Type, Print)
MDALY 670 N CHARLES ST GB GBMC PATIMORE

MD 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

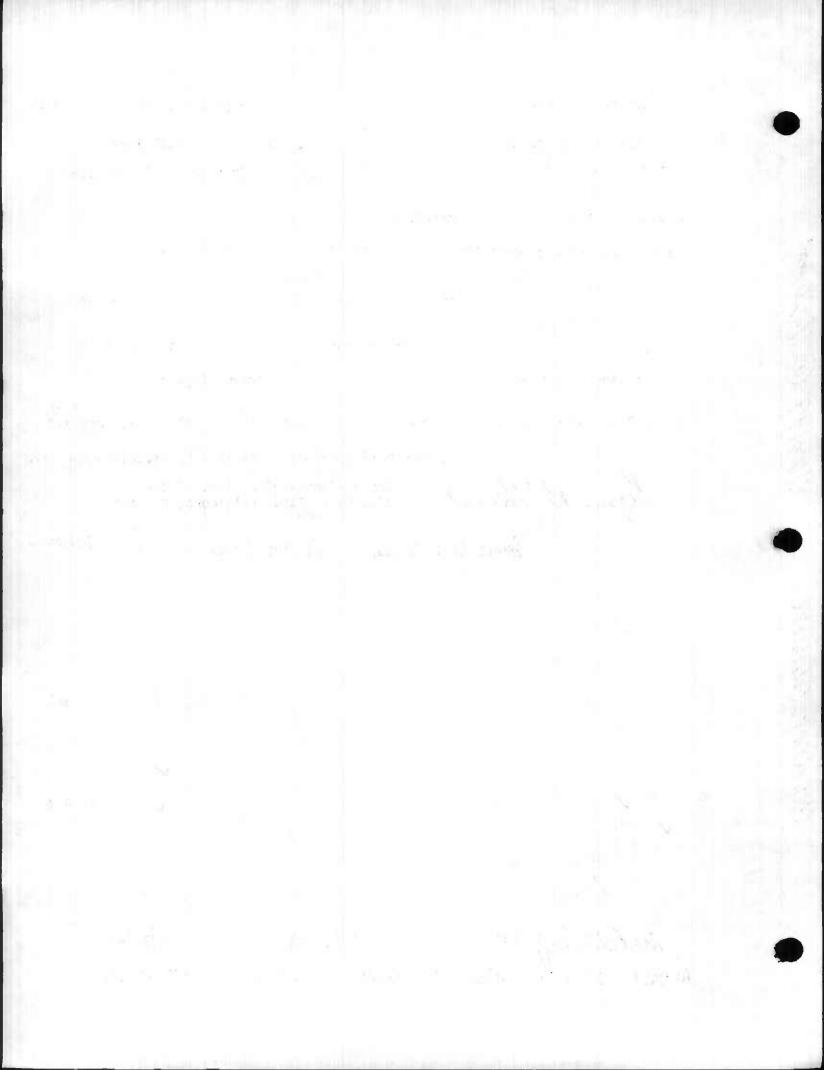
Medicai

31. Date filed (Month Pay CY ear) 32. Regintrer's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

the



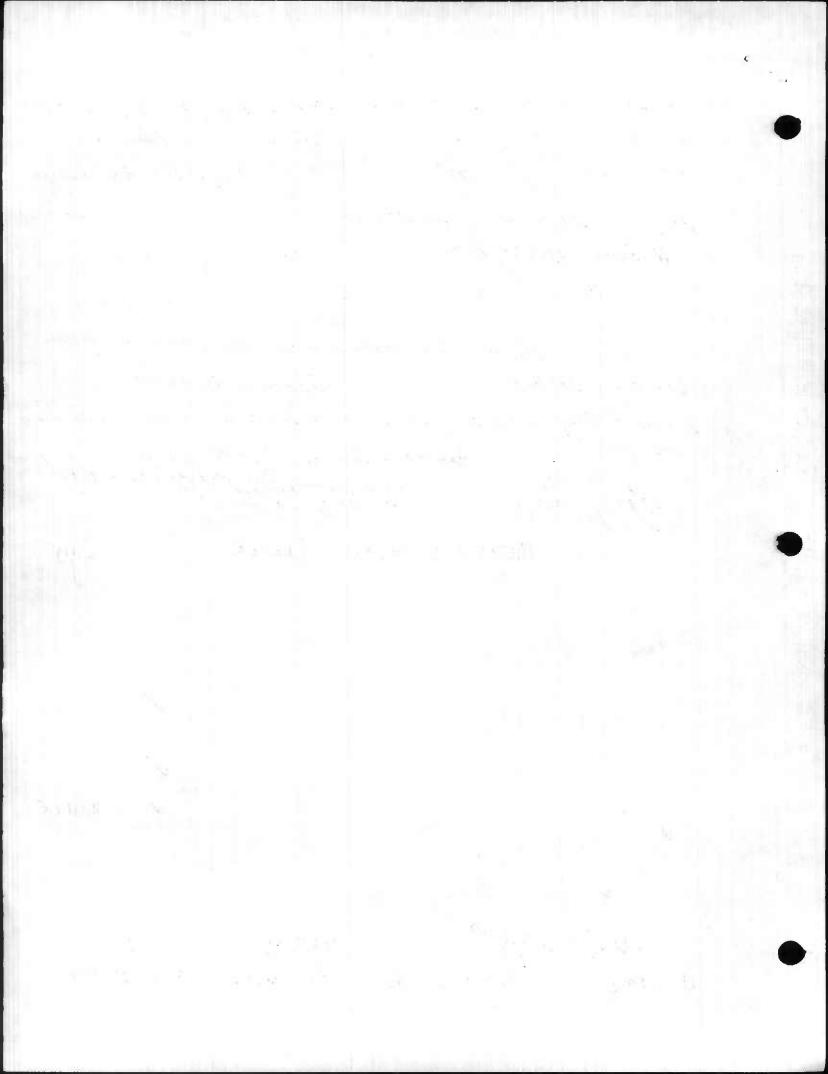
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KOUMBA JASABOROSAW - HARPER **Physician** NALUNGO Month 2:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DUTSING CENTER GILCREST 16 WSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 168 46 8307 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified WOUDLANN Tes 2 No BALTIMOR 10e. Street and Number 288-1 10f. Zip Code 10g. Citizen of What Country? 11 SUMMER florms 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ To If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgln? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married "natural", or 1 Yes 2 No Specity: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired.

SUPERUI SOY— DILLET Core. Worker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CHILDRENS HOME Elementary/Secondary (0-12) College (1-4or 5+) important: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Watson SPARROW WOODFOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/793 2410 WintER BRUCK DR WALKERSUILLE, Mary LAND HUSBANO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State WOORAM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer BALTIMORE for complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** METASTATIC Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Be Completed 1 Yes 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO SILE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manyrer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) SALTIMORE

NUARIES

Registrar



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

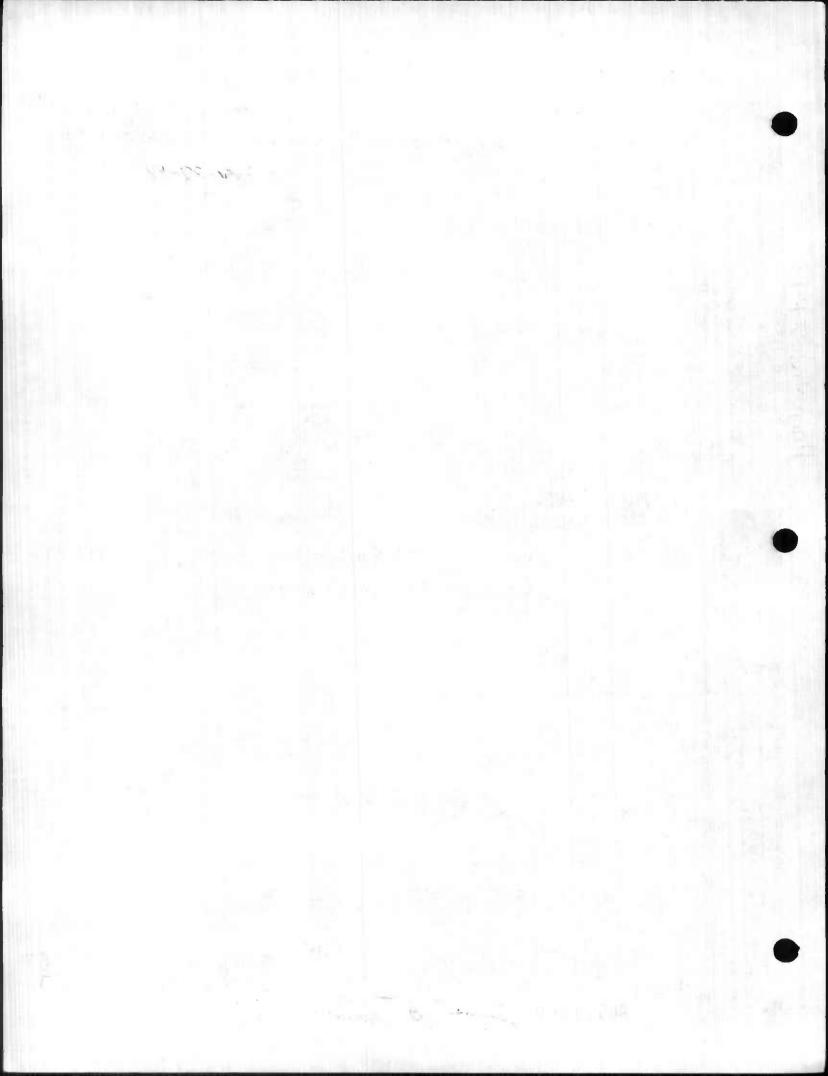
State of Maryland / Department of Health and Mental Hygiene

					ertificate of			7	9 26	554	
Phy	sician	1. Decedent's Name (First, Middle, Li		2. Date of Death Month Day Year 3. Time of							
	edical	Marie E. Hallio	n						99 9:	31 a.m.	
	miner	4a Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Deeth		
		Doctors Communit	y Hospital			Lanham		August 18, 1999 9: August 18, 1999 9: August 18, 1999 9: August 18, 1999 9: Prince Georg Date of Birth (Month, Day, Year) Oct. 1, 1910	ge		
Fune Direc		212-66-9071	Sex 7. Ag	e (In yrs. last birthdi 88 Yrs	Months Days	If Under 24 Hrs. Hours Min.					
P .		Usuat Residence of Decedent 10a. State 10b. County		40- City Town	Lacation				1004		
anylar anylar			10c. City, Town or	Location					ide City Limits ☐ Yes 2 □ No		
N 1	cto	MD Prince	George	Laurel					*	1 102 5 1100	
1215-0020 within 72 hours after death with the Maryland one. then "natural; or Nams 23s or 28s-f show in Medical Essentings must be notified at ompleted by Funeral Director.	10e. Street and Number 410 Greenhill Av	10f. Zip Code 20707		What Country?							
op E	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S. 1	Wes Decedent of H If Yes, specify Cube	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)			ian,	
21215-0020 d within 72 hours after gione. r then 'netural', or H	by Fu	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ P If Yes, Give Year or Dates:	ło	1□ Yes 2⊠ No		- Taxonia				
5-C	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	cedent's Usuat Occupive kind of work done	pation during most of work	ina	16b. Kind of Bu	usiness/Industry		
within then	du	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retired	d)	9				
M DDF	Ö	12	1	Adı	ministrati					ment	
D HATE	9	17. Father's Name (First, Middle, Las)			18. Mother's Name	e (First, Middle, I	Maiden Surnem	den Surneme)		
should be und Mental or marked o	0	William B. Flyn	1			Margare	t J. Ahe	ern			
Mar nd 2 sh lith and 27 le m		19a. Informant's Neme/Reletionship Richard Hallion									
0 - I E E		20a. Method of Disposition		20b. Place of Di	sposition (Neme of	00)	Dete	20c. Location -	City or Town, Si	ata	
Peges mar: If the		1 Donation 5 ☐ Other (Speci			remetory or other place		121 100	7 1	1		
Baltim permit. Peg Department important: P		21. Signature of Fugerel Service Lice		1St. Mar	y's Church 22. Name and Addre		724/99	Laurel	, Maryla	ind	
Balt Pemit. Depart	one		2/7			neral Hom	e, Inc.				
		faneca	Tall	e I	7601 Sand	y Spring	Road, La	aurel,			
		23a. Part 1. Enter the disease, or conshock, or huart failure. List only	plications that caused one cause on each lir	the deeth. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory erro	est,	Interv	oximate ral Between	
Physici		[]		7	_				Onse	t and Death	
/Medic		Immediate Cause (Finel disease or condition	9/2	renor	ua'						
Examin		resulting in death)	-	Due to (or as a con						1	
v 4	<u> </u>							-//-	10	lays.	
et pu	Examiner	Sequentially list conditions,	b	Due to (or as a con	sequence of):					0	
60, be execut		Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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25 50 10	-	resulting in ceattr) cast									
Box eath cer	2		d						-		
	Physician/N	Part II. Other significant conditions of	setributing to death bu	it not resulting in the	underlying cause div	ren in Pert I	23b. Did to	bacco una co	ntribute to the c	ause of death?	
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2 28	by P	ff	Themes	r 5 de	blace	-	10.11	es 20 140	O Processy	4 - Olikilowii	
Records, se law requires to shas been signed to 2 should be	D		0, 0	1.	1 4	10:	24a. Wes a	n autopsv	24b. Wera au	opsy tindings	
Cord requir been s	Completed		Longo	your	heard T.	anne			available	prior to	
A see	dw		(/				,		of death?	,	
Carte Na Market			· ·				112 Ye	es 2 No	1 Tyes	2/21No	
Vital I ician: Th certificate	88	25. Was case referred to medical axaminer?	and the same of			26. Place of Deat	h (Check only on	16)			
Of Physics of This of	2	1 ☐ Yes 2 ☑ No	Hospitat: 1 Inpatie	nt 2 ER/Outper		4LI Nursing Ho	me 5 Reside	ence 6 Oth	er (Specify)		
	Ë	27. Manner of Death 1 ☑Netural 5 ☑ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time		ry at	28d. Describe ho	ow injury occur	red		
Vision Attending r death, ector: Alls	atio	2 Accident investigation				Yes 2 □No					
	Certification:	3 Suicide 6 Could not be determined	9 28e. Place of Inju	ry - At home, tarm,	street, fectory, office				per or Rural Rout	e Number,	
	ě	4 D HOMEGO	building, etc	. (Эрвспу)			City or Town	1, 3(8(8)			
Hospital 24 hours of Funeral (edical (29e. Certifier (Check only 2 Hedical Exe	Miner: On the basis of	examination and/or	ath occurred at the tir investigation, in my o	me, date and place, pinion, death occur	end due to the cared et the time, da	ause(s) and ma ate and place,	anner as stated. and due to the c	ause(s)	
4 4 4 4	Me	29b. Signature and title of certifier	end menner sta	teu.	29c, Licens	e number	2	9d Dete signe	d (Month Day V	(opr)	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		250. Signature and little of comment	No ME)		24283		8.19	99.	oar)	
/2	j.,	30. Name and address of person when	completed cause of de	eath (Item 23a)/(Tvr	ne, Print) /	11/1		Mnn	0707		
4	0	M. Just	10631	Balta	worl H	Ve Lar	usor,	IN. d	10/		
	State	31. Date filed (Moylift, Day, Year)	32. Registra	r's Signeture							
	istrar	AUG 24 19	90	/							
DHMH 16 Rev		Ama 0 = 10	99 Pines	B.	Spark	/					

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nended Item#8 per FH G774 1. Decedent's Nama (First, Middle, La	8/26/99 (st)	C	Pertificate o	r Death		Reg te of Death	. No.	610	3. Tima of Death			
ian cal Joseph G. Hannor		Mo	GUST	21 1°		0:45 PM						
1er 4a Facility Name (If not institution, git	e street end numbe	*	=	_	wn, or Location	of Death	4c. County		OC			
FRANKLIN SQUI		PITAL C			DALE	te of Birth		TIME	400			
		O Yn	Months Day		Min. 10	onth, Day, Y	1 49	9. Birthplac Country, Maryla	e (Steta or Foreign) vid			
Usual Residence of Decedent		Lie di T					70					
10a. Stete 10b. County		10c. City, Town o						10d.	Inside City Limits 1 ☐ Yes 2 ☐ No			
Maryland Baltin 10e. Street and Number	ione	Baltimo	10f. Zip Code	•		100	1. Citizen of \	What Country				
8618 Saxon Circle	Le.		2123	6			U.S.A					
11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 N If Yes, Giva Yeer or Detes	No	13. Was Decedent of If Yes, specify Co			es or No- etc.)		ce - American ck, White, etc v: Whit				
	ducation	16a. D	ecedent's Usual Occ	cupation	t of working	16	Sb. Kind of B	usiness/Indus	atry			
15. Decedent's E (Specify only highest grant property only highest grant property) Elementary/Secondary (0-12)	College (1-4o	(5+)	iive kind of work dor le. DO NOT use reti atisticia		, or morning	R	+6006	em Ste	08			
17. Fether's Nema (First, Middla, Last	years	31	unsucia		er's Name (First,				ec			
Joseph F. Hannor	1			Em	ily Bre	inich						
19e. Informant's Neme/Reletionship (Barbara A. Hanno	Type, Print) IN (Wife	19b. N	leiling Address (Stre 8618 Saxo					State, Zip Co 21236	ode)			
20a. Method of Disposition 1X Burial 2 Cremetion 3 C	Removal from Stet	cemetery,	isposition (Name of crematory or other p		Date			City or Town				
4 □ Donetion 5 □ Other (Special	(y)	Vulaney	Valley M			25, 19	199 121	monum	, MV			
1	21. Signeture of Funeral Service Licensee 22. Nama and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Deeth Approximate Interval Between Onset and Deeth											
23a. Pert1. Enter the disease, or con-	plications that cause	ed the death. Do not	9705 Be enter the mode of d	lair R	oad, Ba	ltimor	ie, MD	2123	pproximate			
shock, or heart failure. Next how	one cause on each	line.						O	terval Between nset and Deeth			
Immediate Cause (Finel disease or condition	RESP	PIRATOR	Y FAIL	URE				3	DAYS			
resulting In deeth)	F 000	Due to (or as a cor		-	٨							
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Sequentially list conditions, if eny, leading to immediate uses. Enter Underlying Cause (Disease or injury		Due to for as a cor	isaquerica or).					1				
Cause (Disease or injury that initialed events resulting in death) Last	C	Due to (or as a con	sequence of):									
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Bod II Other plantilleant and state of		h. h a - a - (M/ 1- M	Company of the control of the contro		1 0	nh Midah		-0.100.2-0.2				
Pert II. Other algorificant conditions of	onthouting to death	but not resulting in the	e underlying cause	given in Peri i	. 2		2 No	3 ☐ Probab	ne cause of death?			
by F												
D					24	la. Was an performe	autopsy ed?	eveila	autopsy tindings able prior to eletion of cause			
JQ L								of dea	ath?			
Ö						1 Yes		1 D Y	fes 2□ No			
25. Wes case referred to medical examiner? 1 Yes 2 No	Hospitel: Impai	tient 2 ER/Outp	atient 3 DOA	Wher	of Deeth (Checursing Home 5			(Coosits)				
	28a. Dete of In	jury 28b. Tim	e of 28c. In				injury occur					
1 Netural 5 Pending 2 Accident investigation		lay Year) Inju		Yes 2	No							
27. Manner of Deeth 1 Netural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 27. Manner of Deeth 5 Pending investigation investigation 6 Could not be determined	286. Place of II	njury - At home, fermetc. (Specify)	, street, fectory, offic	> 0	28f. Lo	cation (Stre ly or Town,	et end Numl Stete)	ber or Rural R	loute Number,			
29e. Certifier 1 Certifying Pr (Check only one) 2 Medical Exer	ysician: To the bes niner: On the basis and manner s	t of my knowledge, d of examination and/o stated.	eath occurred at the r investigation, in m	time, date an y opinion, dea	d place, and du th occurred at th	e to the cau ne time, date	se(s) and mi e and place,	anner as state and due to th	ed. le cause(s)			
29b. Signeture and title of certifier	***************************************			ense number	2.0	290	I. Date signe	d (Month, Da	y, Year)			
				9659	12		82	1/9	9			
30. Neme and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print) IN SAUARI	C = 0(00	MODE	MADA	J. A. Im ~	227			
	DI BULL TO											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Mary Claire Higgs 045B August 22 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Yeer | 1f Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | MAY 12, 1940 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months 1□M 20 F 200-30-3389 59 Yrs. Pennsylvania Usual Residence of Decadent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√7 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Royal Oak Drive 21015 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Work Law Firm 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. Unk. Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 326 Royal Oak Drive Bel Air, MD 21015 Dete 20c. Location - City or Town, State Richard Joseph Higgs/husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 8/23/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fun ral Service License Cremation Society of Maryland, Inc. 299 Frederick Road McDonald Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER MONTHS Due to (or es a consequence of): UNG MIZTASTASIS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest BRAIN METASTASIS Due to (or as a consequenca of): RIZSPITORY FATURIZ WEEK Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown BRONKINDS OBSTRUCTION 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1∭Inpatient 2□ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 No Investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide

physician a s the burial-I Division of Vital Records, P.O. Box 68760 Hggs, many Claire 950 certificate or Attending Physician: director, this funeral After Director: A 24 hours after Funeral Dire letely filled in t To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

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Examiner must be r

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parmit. Pages 1 and 2 should be fised within 1 Department of Health and Montal Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event. the Med

Physician

/Medical

Examiner

Examiner

Physician/Medical

à

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

the Marylar

Baltimore, Maryland 21215-0020

State Registrar 31. Date filed (Month, Day, Year) AUG 24 1999

29b. Signeture end title of cartifier

neeven

SIPARM A

MD

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

Mb

32. Registrar's Signature

1814 2

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

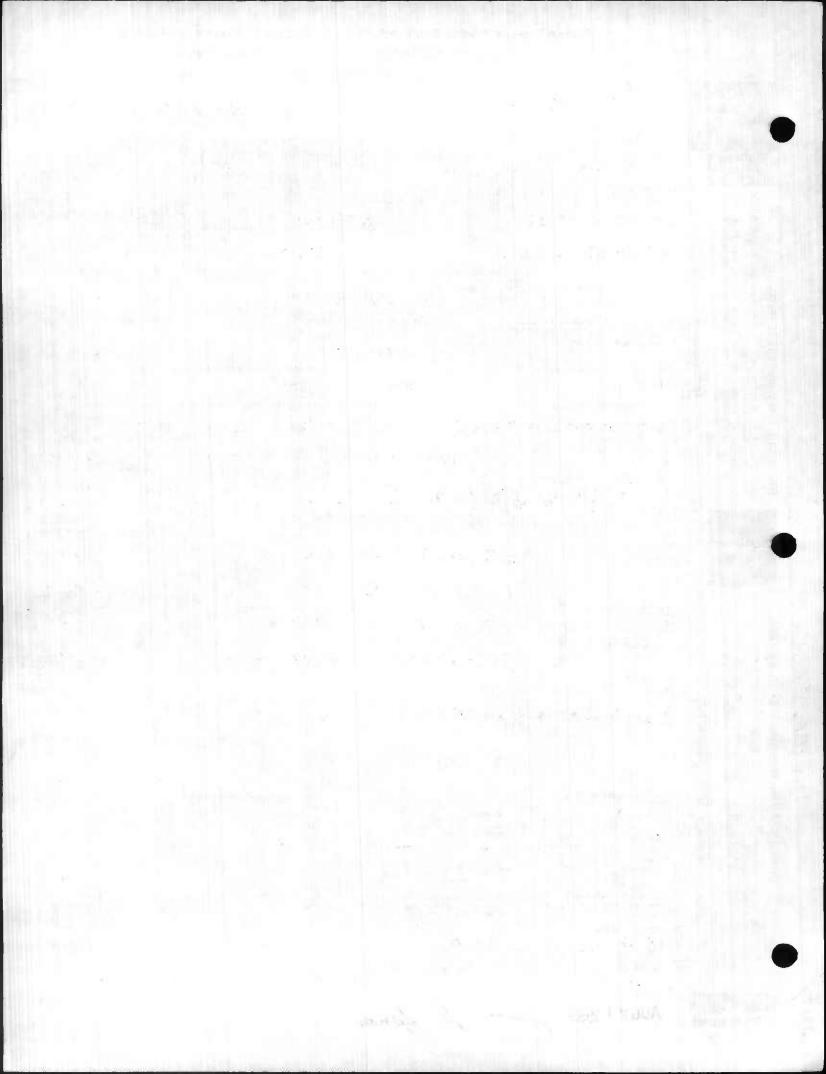
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

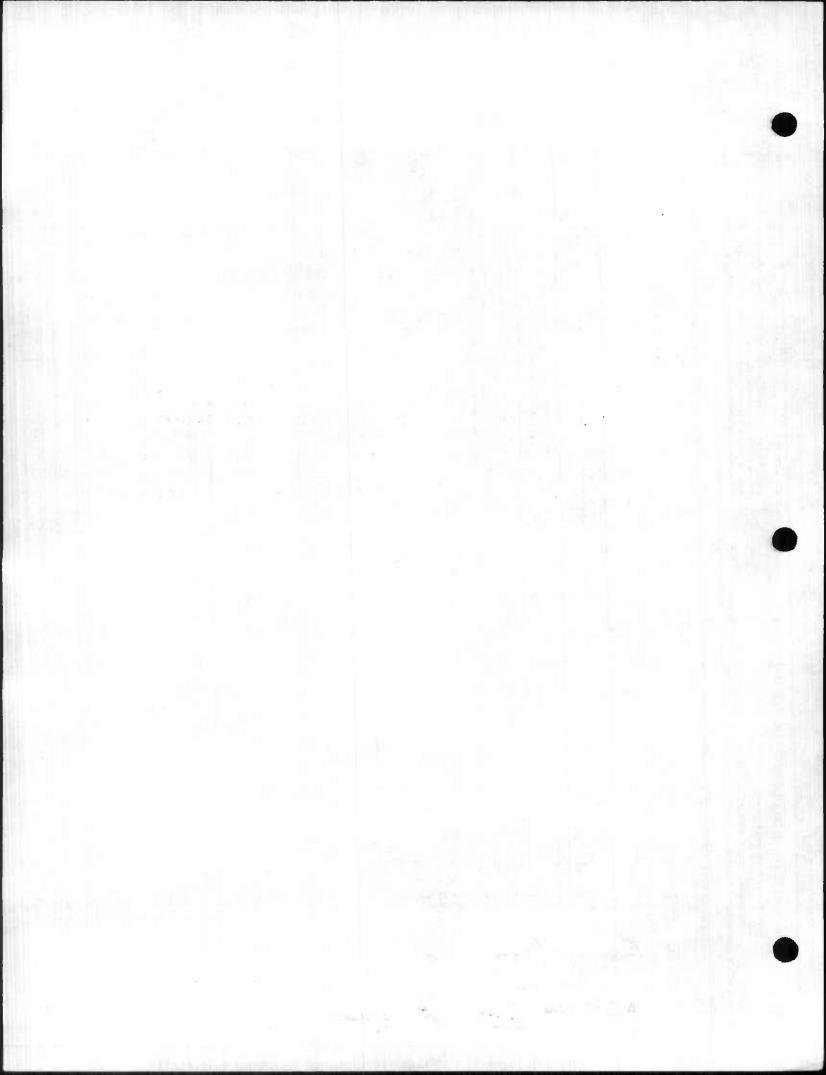
EL AIR RD

29d. Date signed (Month, Day, Year)

MO 21047

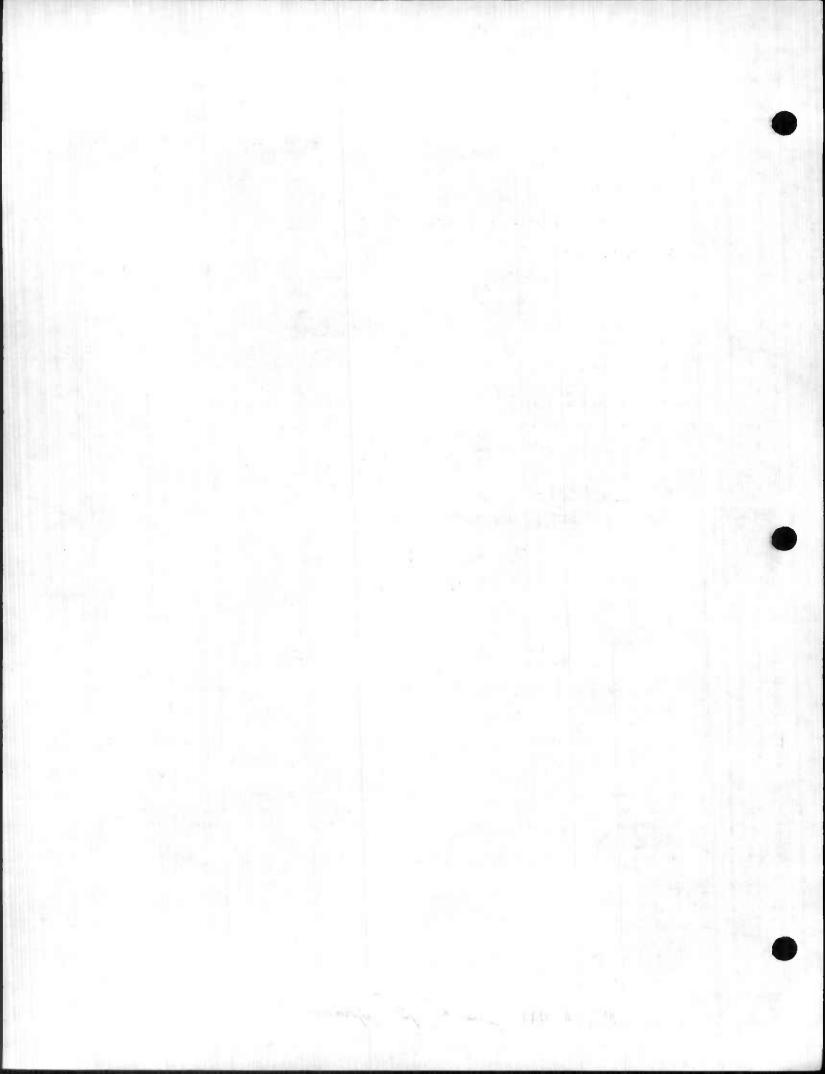


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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Re	eg. No.	26558		
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Patricia Kathleen Heath	2. Date of Death Month August	1999, 1999	3. Time of Death eer 6:45 am		
Examiner	4a Facility Name (If not institution, give street end number) 463 Walnut Drive Edgewate		4c. County of Anne A:			
Funeral Director	5. Social Security Number 213-80-1649 6. Sex 1 Months Days Hours Min.	8. Date of Birth	Year) 9.	Birthplace (State or Foreign Country) Maryland		
yland	Usuel Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location			10d. Inside City Limits		
o Ma	MD Anne Arundel Edgewater		1 🗆 Yes			
ath with the Maryland 23e or 28e-f show unt be notified at		0g. Citizen of Wha	at Country?			
Nerra Nerra Dar m	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Detes:	specify Yes or No- to Rican, etc.)	14. Rece -	American Indian, White, etc. White		
d 2 should be flied within 72 hours at the and beat lygisters. The sun wanted other than "natural", or traumatic event, the Medical Exam. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of work		16b. Kind of Business/Industry			
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Mental H Mental H Mental H Me ever	77171					
2 short and N lis man in	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Re	eta, Zip Code)				
	Joan R. Welsh (Mother) 463 Walnut Drive, Edg	ewater, 1	MD 21037			
emit. Pages 1 as Appartment of Hea reportant: if Item my Injury or othe EDS.	20e. Method of Disposition 1		20c.Location-Cit Baltimore			
permit. Depart Importu any Inj ance.	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Hardesty Funeral 12 Ridgely Avenue			21401		
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart feilure. List only one ceuse on each line.			Approximata Interval Between Onset end Deeth		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Mutuatuh c mullan oma (M	ular		ZYEARS		
death certificate be executed e attending physician and of for use as the burial-transit siciaryMedical Examiner						
at the death certification of the attending stached for use a Physician/M	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to	bacco une contri	buts to the cause of death?		
es that the igned by the be detache		1 🗆 Ye	a 2□ No 3	Probably 4 Unknown		
aw requir		24a. Wes ar perform	n autopsy ned?	24b. Wera autopsy findings available prior to completion of cause of deeth?		
The law page 2		1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No		
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State of Maryland / Department of Health and Mental Hygiene Q Q Q C C C

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D26358 AUG. 23, FIGG 30. Name and modifies of person who completed cause of death (Item 23e) (Type, Print) TUHN WEITER, MS - PRINCEFFREDERICE, MS 206)8		Hospital 4 hours Funeral tely filled	- 1	(Uneck only 2 Medical	Examiner: On the basis of	axamination en	, deeth o	occurred at the t stigetion, in my	lme, date end opinion, deeth	plece, and due	to the cause time, date	se(a) and me and plece,	enner es stat and due to t	ted. he cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death HARRISON 19, 1999 2:35 PM Everette August 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Joseph Richey House Hospice Baltimore Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct • 18,1943 6. Sex 10 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 55 Yrs. 215 42 5643 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21217 United States 930 Chauncey Ave. 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Black. Specify 3 Widowed 4 Noivorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Artist Self Employed 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Alethea Harrison Peters Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt.1 Box 446R, Kearneysville, WV Bettye Harrison-Burns / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/21/99 Baltimore, MD Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 21286 23a. Pert1. Enfer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 8717 Green Pastures Dr., Baltimore, MD Immediate Cause (Final disease or condition resulting in deeth) Responsions amost Minholes Due to (or as a consequence of): Widespread palmonary a cerebral metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last c. Non-smill cell adenocardious of @ upper lung lobe Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown mastoiditis 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

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25. Was cese referred to medicel examiner?

27. Manner of Deeth Netural 2 Accident

4 | Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier dolle B. Bina in D 29c. License number 202175 29d. Date signed (Month, Dev. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

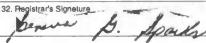
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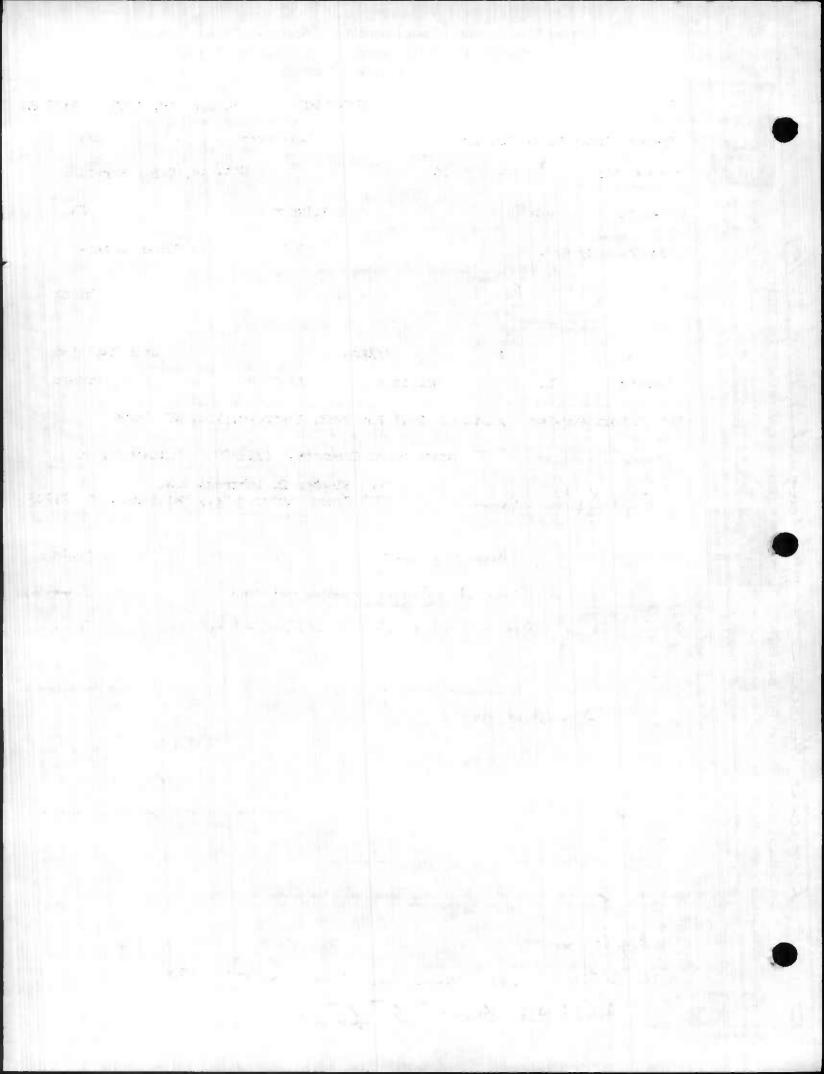
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8 To the To The To the I



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death AMEND#1 PER MD. G775 9-18-99 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ELIJAH ANTHONY JOHNSON SR. Month **Physician** IAH 0625 21 1999 AUGUST ANTHONY /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** MARYLAND HOSPITAL BALTIMORE NIVERSIMY OF If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Days 20-84-9658 36 Mary Mus Director 160.24 Usual Residence of Decedent the Meryland 10a. Slete 10c. City, Town or Location 10d. Inside City Limits ahow Entimase Mes 2 No Director Kerylins 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21230 64 WaskinGTON Funerai filed within 72 hours after death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 21 No
If Yes, Give 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 Married 1 Ves 2 No Specify: 21215-0020 "natural", or Specify: Black p 3 □ Widowed 4 □ Divorced Yeer or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) EASTERN STANDARD permit. Peges 1 and 2 should be filed withir Department of Health end Mental Hygiene. Important: If Itam 27 ia marked other than any Injury or other traumatic avant, the Many Injury or other traumatic avant. Elementery/Secondary (0-12) College (1-4or 5+) Janiter MonufrehrerEs 24GAYS Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAH Marc HARRIS LOHNSON 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) STEP-4012 Edwarpson AVE Baltinore, and 21229 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 21. Signature of Funerel Service Licenses

22. Name and Address of Facility CHATURN - HANN

23. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 3 Removel from Stele Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) 2 1445 SEPS15 disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 950 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s 1□ Yes 2⊠ No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1 (Xinpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Nelural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homicide ni bellit Hospital 29e. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2

State

Registrar

H. AYALA 31. Date filed (Month, Day, Year) AUG 2 4 1999

29b. Signeture and little of certifier

22 S. GREENE 57 32. Registrar's Signature

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

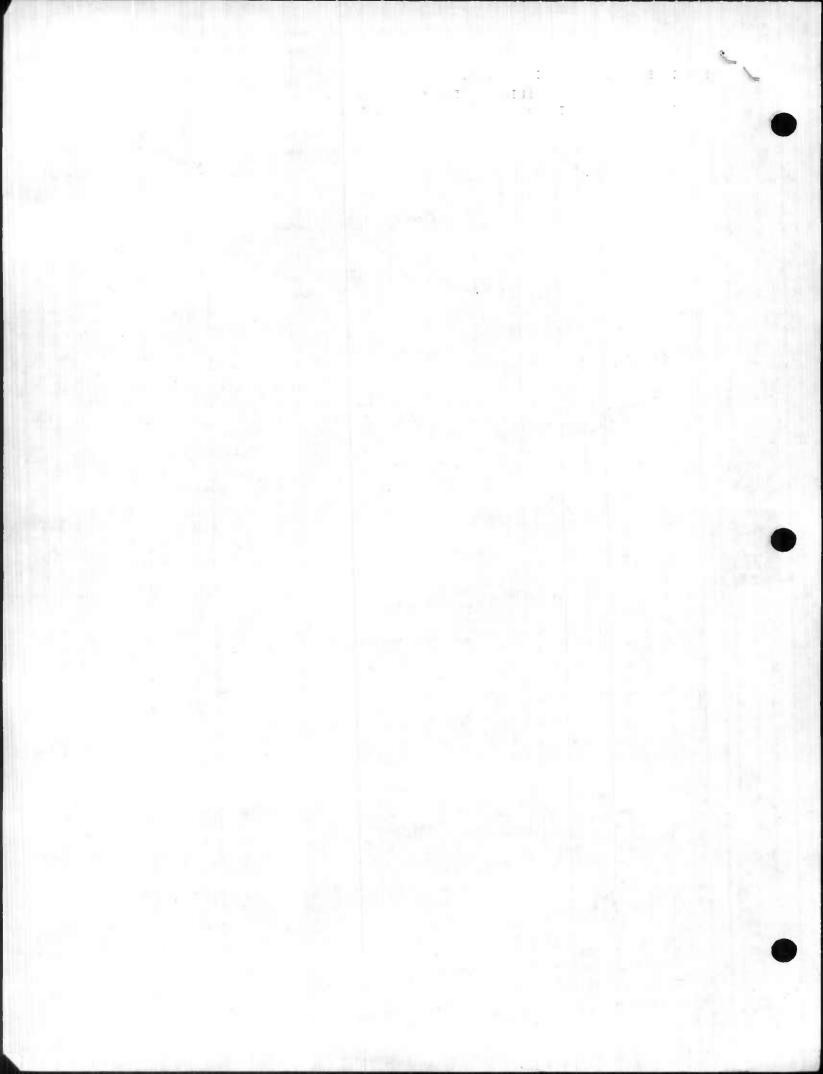
29c. License number

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MD

29d. Date signed (Month, Day, Year)

AUGUST 21 1999



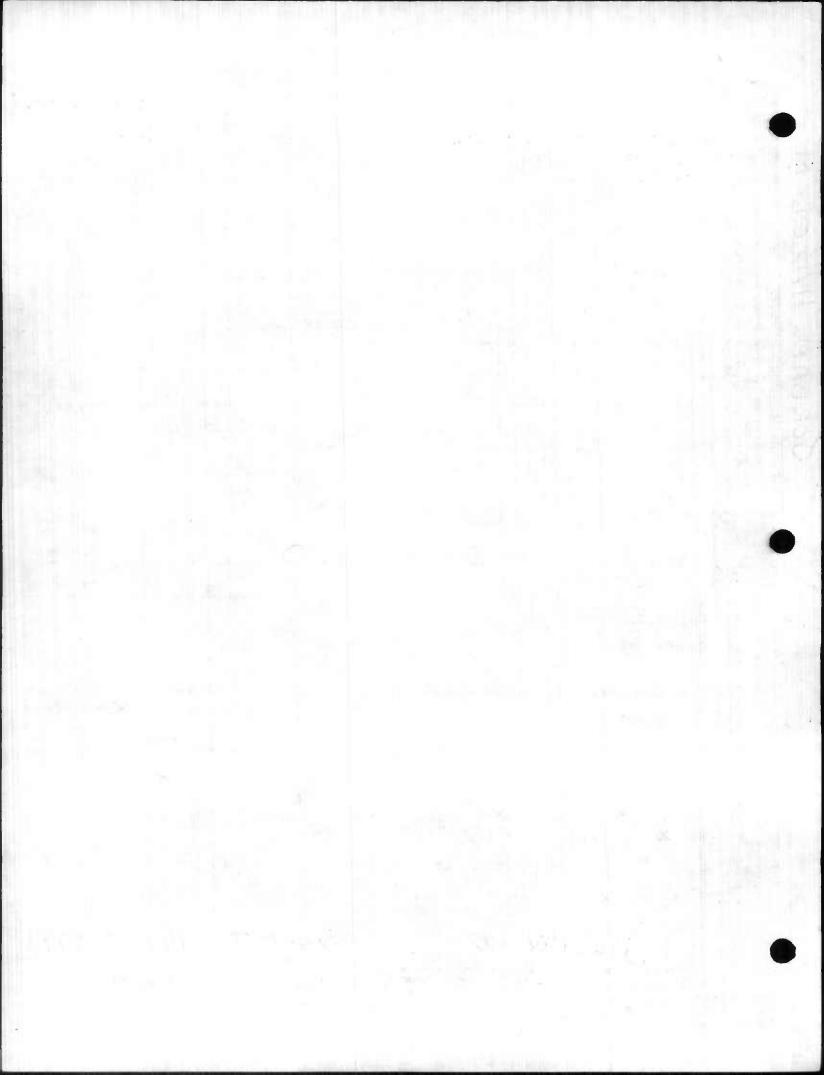
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Hazel H AUGUST 1999 4:45 A.M. Jordan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F Months Hours 218-32-9972 Director December 15,1919 Baltimore, Maryland Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or hama 23a or 28a-f ahow treumstic event, the lead call Examinar must be nottled at 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 吉 4401 Ridge Road 21236 USA Funeral 14. Raca - American Indian. 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3℃Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7: and Mentel Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Antique Dealer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be 1 ent of Health and Mentel I James F Hampshire Sadie Boulden 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tre once. Dianne Younts 5718 Arnhem Road Baltimore, Maryland 21206 of Disposition (Name of Date 20c. Location 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Cardens of Faith Cem. August 20, 1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examine lician and burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Box 68760 Physician/Medical Due to (or as a consequence of) 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by i 3 Probably 4 Unknown 1 Yas 2 No Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Anpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Tyes 2 No death. investigation 2 Accident hours efter death 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide pelli 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Fune completely f To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) AUG. 19, 1999

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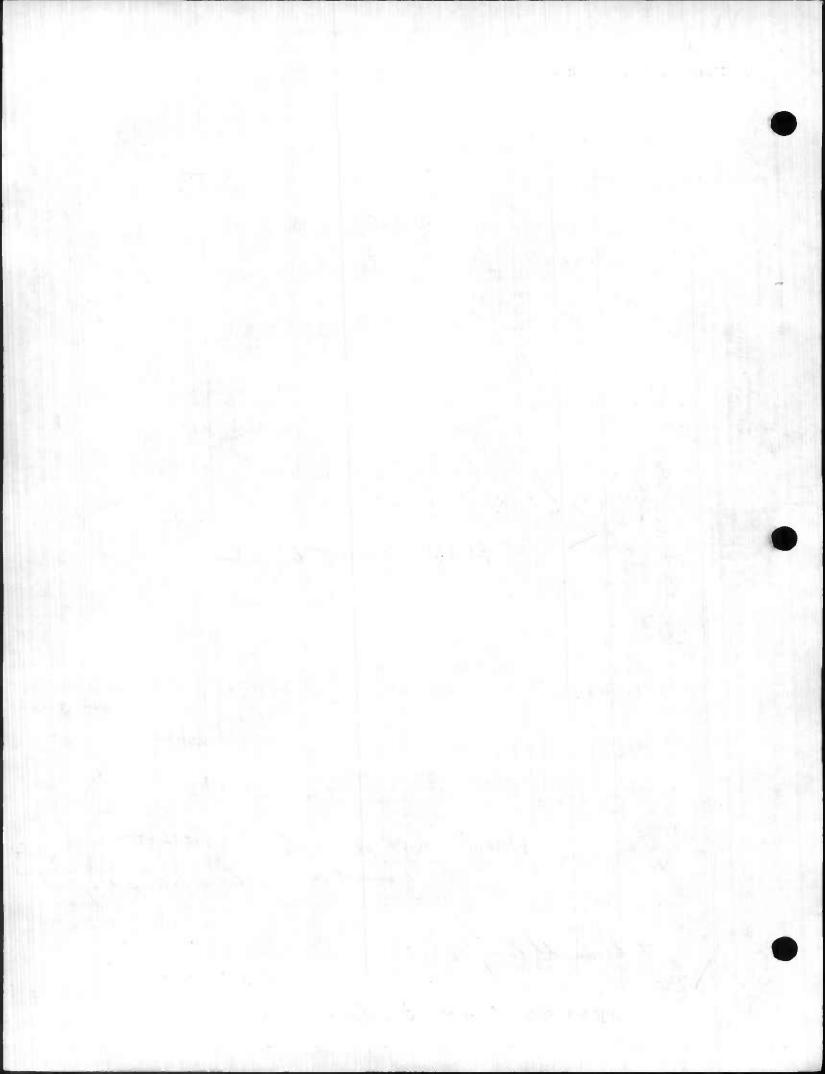
State Registrar 32 Registrare Signature

BaH. MD 21204



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99-4814-510	State of Maryland / Department of Health and M	Mental Hygiene				
AMEND ITEM:	8 PER F.H. G774 8-24-99 WR. Certificate of Death	Reg. No.	9 26563			
	Decedent's Neme (First, Middle, Last)	2. Dete of Deeth	3. Tima of Death			
Physician	Shawn JACKSON	AUGUST 17, 1	999 1935 PM			
/Medical Examiner	4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Lo					
	JOHNS HOPKINS HOSPITAL BALTIMOR	ORE CITY NA				
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min.	8. Data of Birth5 - 30 - 83 (Month, Dey, Year)	Birthplaca (Steta or Foreign Country)			
Director	213-04-0381 12M 20F /6 Yrs. Months Days Hours Min.	5/30/99	Md.			
2 .	Usual Residence of Decedent					
aryta dat	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
title M	Md. N/A BAHimore					
vin he Ma i or 28a-f s be notified Director	10e. Street and Number	10g. Citizen of	What Country?			
Unter death with the Maryla there 23s or 23s-f should stort must be notified at Funeral Director	1600 Cliffview AVE. 21213	0,5,	A.			
Herra Herra Dar m	11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Spr. 14. Spr. 15. Specify Cuban, Maxican, Puarto	Rican, atc.)	ece - Amarican Indien, eck, Whita, etc.			
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Saltimore emit. Pages 1 Appartment of He mportant. If then my Injury or oth ISS.	21. Signature of Funerel Service Licenses 22. Nema end Address of Fecility . 2	off Suresal	Lland Contract			
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Chusisian	23a. Part. Enter the disaese or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac of abook or haart failure. List only one ceuse on each line.	or respiratory arrast,	Interval Between Onset and Deeth			
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60, be executed ician and burial-transi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.					
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Division or Attending after death. Director: After d in by the fune ertification	4 Distributed building of (Consist)	28f. Location (Street and Nun Gity or Town, State)	nber or Rural Route Number.			
Division of tall or Attending P as after death. al Director: After the funer led in by the funer. Certification:	building, atc. (Specify)	Avenue Belton	500 block Cliff you			
	29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, Check only WMedical Examiner: On the basis of examination and/or investigation in my opinion, death occurred.					
he Hosp in 24 hou he Funer pletely fil	(Check only one) **Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred menner steled.	red at the time, data and place	o, and due to the causa(s)			
To troth	29b. Signeture and title of certifier 29c. Licensa number		ned (Month, Dey, Year)			
0 1	Theology of Kense was	AUGUST	18, 1999			
() \	30. Neme and eddress of person who completed cause if death (Item 23a) (Type, Print)					
MVVI	THEORIRE MIKING 111 Penn Street, Baltimore,	Maryland 2120	1			
State	31. Deta filed (Month, Dey, Year) 32. Registrar's Signature					
Registrar	AUG 2 4 1999 V wa B. Sparks					

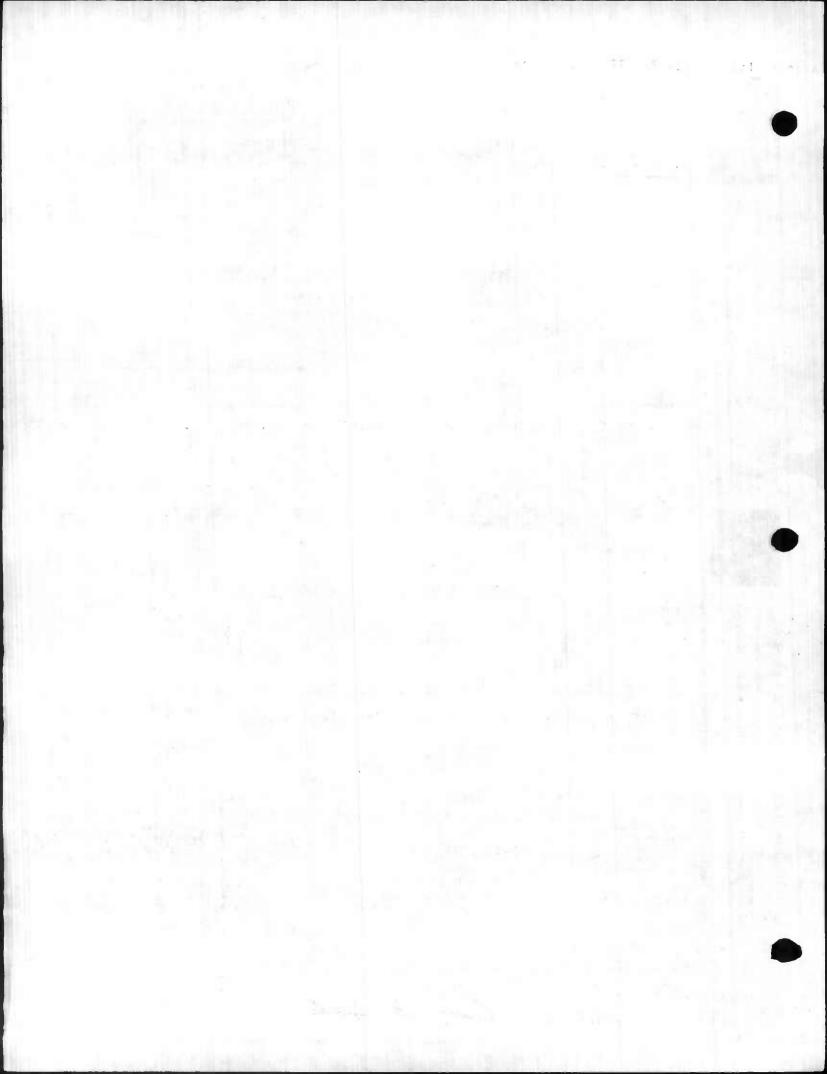


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State of Maryland / Department of Health and Mental Hygiene Amended Item 4, PER FH G775 9/29/99dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 1512 Charles Johnson 1999 18 ANG /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore Bayview Center If Under 1 Yeer If Under 24 Hrs. Social Security Number 13-96-0352 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1₺M 2□ F Director 22 NOV 6 1976 3-60-555 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits r 28e-f ahow 10c. City, Town or Location XX Yes 2 No Director MARYLAND N/A BALTIMORE CITY å. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Meniel Hygiene.
Important: if item 27 is marked other than "natural", or itema 23e or set in Injury or other traumatic event, the Medical Essentine must be no bose. 4315 KATHLAND AVENUE 21207 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ №0 If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOTEL. 12 yrs FRONT DESK MANAGER l yr 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 CHARLES JOHNSON SR. CHERYL E DAWES 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) CHARLES JOHNSON SR/Father 4315 Kathland Avenue, Baltimore, Maryland 21207 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date PBurial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 8-23-99 BALTIMORE, MARYLAND 21. Signatura & Funeral Service License 22. Neme end Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Selsi5 Examiner Examiner ettending physicien and for use as the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown eigned by multiorgan failure - liver, kidney à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed bacteremia and certificata 1 ☐ Yas 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this To the Hospital or Attending Ph within 24 hours etter deeth. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: insel 28f. Location (Street and Number or Rural Route Number, City of Town, State) 1 Natural 5 Pending 1□ Yes 2 No investigation luck Jule 20 1999 2 ☐ Accident Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide KATHLAND AVE, 4315 Busement of home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifiq 29c. License number 29d. Date signed (Month, Day, Year) 18199 R5-000 AJG 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Himore MD 2123 1900 Thames offe #407 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State AUG 2 4 1999

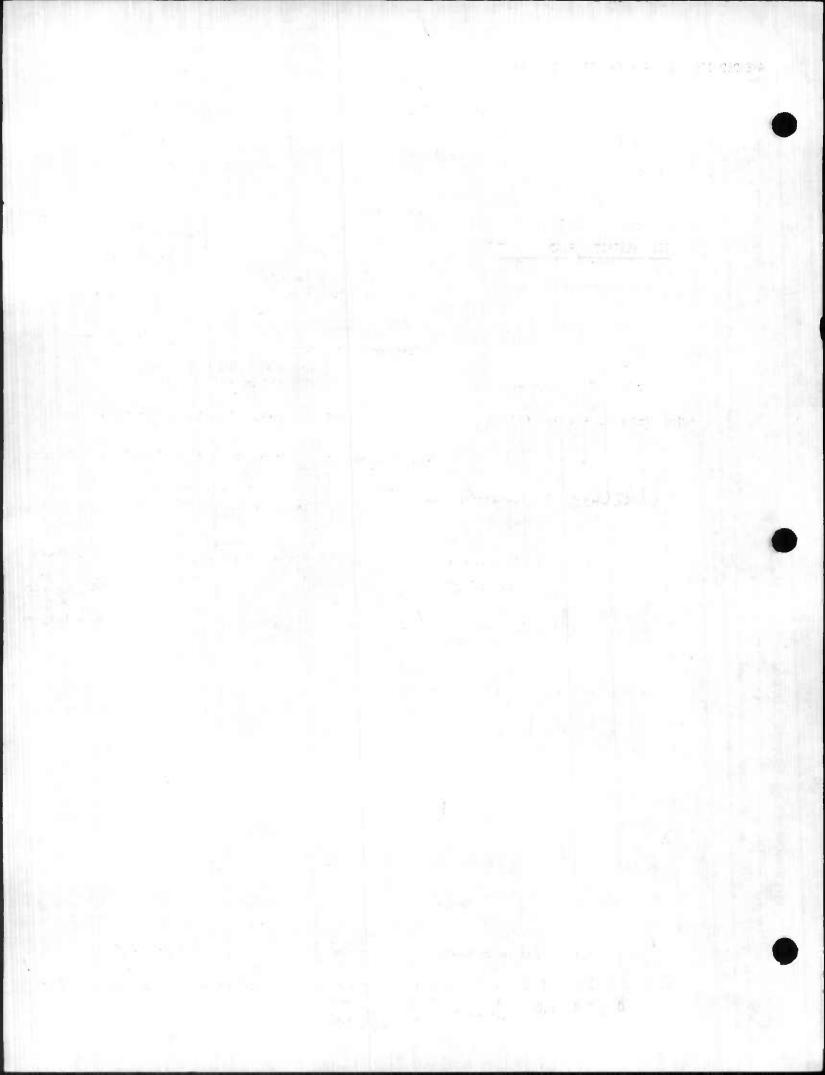
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Registrar



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niner	Paul Michael Kenney, Sr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L							Location of Deal	th 4c. County	of Death	
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ctor	Maryland B	altimo	ore		Timor	nium					1 ☐ Yes 2 ☐ No
Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V		ntry?
runeral	2214 WESTRIDGE ROAD 2214 Wedtridge Road 21093 11. Meritel Stetus 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (S							pacifu Vac or N	U. S.		can Indien,
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ň	19a. Informant's Neme/Reletionship (Type, Print) Mrs Gale M. Kenney (Wife) 19b. Meiling Address (Street and Number or Rural Route Number, City or To										
	20e. Method of Disposition	netion 3 🗆		cem	etery, crem	atory or other plea	m. Gards	Date 8-23-9	20c. Location -		own, Steta , Maryland
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cel illication.	3 ☐ Suicide 6 ☐ 6	Could not be determined						28f. Location City or To	(Street and Numb wn, State)	er or Rurs	al Route Number,
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	200. Signature end title of	certifier	1-0			29c. Licens	e number		29d. Date signer	d (Month,	Day, Year)
	Den	80 T.	Sulma	re		202	325		8/20/	79	
	30. Neme and address of	son who c	ompleted cause of	death (Item 2	3a) (Type, P	rint)		111	1000	1	- /
	GEORG	SE	T. GIL	MORE	MD	13221-	3 1 M	llam	are Rd	Tim	an mon
	31. Dete filed (Month Day,										



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) August 22 1999 Carroll Edwin Lloyd, Sr. 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. N/A5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 ₹M 2 □ F Months Deys Hours 216.34.4818 Yrs. Jan.17,1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2815 Sunset Drive 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, Whife, efc. 1 XYes 2 No 1959 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Police Officer Law Enforecement 18. Mofher's Name (First, Middle, Malden Surneme) 17. Father's Name (First, Middle, Last) Charles T. Lloyd Mary Grap 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gladys R. Lloyd/Wife 2815 Sunset Dr. Baltimore, Md. 21223 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 8/26 Baltimore, MD 21. Signefure of Funeral Service Licenses 22. Name and Address of Facility Sterling-Ashton-Schwab lan 21228 736 Edmondson Ave. Catonsville, Md. 23a. Part. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shirts, at heart feilure. Use only one cause on each line. Immediate Cause (Final . ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): SEVERE DIFFUSE CORONARY ARTERY DISEASE Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uss contribute to the cause of death? 18 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy pariormed? hypertension non insulin dependent diabetes mellitus 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 PNatural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Leathfying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 29a. Certifier (Check only one) 2 Madfcaf Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29c. License number

1) 22648

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Medical To the I within 2

24 hours a Funerel E

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiona. Important: If item 27 ie marked other than "natural", or item eny injury or other treumatic event, the Madical Exemption

Physician /Medicai

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Certification: To

State Registrar

31. Dete filed (Month, Day, Year) **DHMH 16 Rsv 6/95**

29b. Signeture end fitte of certifier

AUG 2 4 1999

nd eddress of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Dete signed (Month, Dey, Year)

August 22, 1899

Jerome I. SNYDER, M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

the straightful or published when the metal the Service Street

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Diameter in		Decedant's Name (First, Middla, L.	Last)		Certificate of	Death	2. Data of De	Reg. No.		3. Time of Deal	
Physic		LANZGICE	LEIGHT				Month Bullet	Day 20	Yaer 799	10:40 P	
/Medi Examii		4a. Facility Nama (If not institution, g	4b. City, Town, or L	ocation of Deat		of Death					
		Keswick Multi	care Cent	ter		Baltim	ore	N/A	A		
Funeral Director		215-01-5718	Sex 7. Ag	9 (In yrs. last bii 79	thday) If Undar 1 Yeer Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Bi (Month, Di MAY Of	th ay, Year) 5, 1920		yland	
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f sh	ō	MD Balti	more		Parkton					1 ☐ Yes 20	
a or 28a	Funeral Director	10e. Street and Number 1929 Bulls Sa	awmill Roa	ad	10f. Zlp Coda 21053	3		10g. Citizan ot W USA	hat Countr	y?	
ms 2,	Jera	11. Marital Status	12. Wes Decedant I	Evar in U,S.	13. Was Dacadant of H	Hispenic Origin? (Sp	ecify Yes or No	o- 14. Reca	- Amarica	n Indian,	
And Mentel Hygiene. The Mentel Hygiene and Mentel or items 23a or 28a-f show imatic evant, the Medical Examiner must be notified a	by	1 ☐ Naver Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armad Forces? 1 V Yas 2 1 If Yes, Give Year or Datas:	ww II	13. Was Dacadant of Hispenic Origin? (Silf Yes, specify Cuben, Maxican, Puarti I □ Yas 2√2 No Specify:		Rican, etc.)	Specify:	whita, at Wh:	ite	
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		Dawn F. McDonald Maryland, Inc. 299 Frederick Rd. Baltimore, MD 2									
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AND 14 May 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 6:38 pm PSCOM b 1999 4a Facility Name (If not Institution, give street en number) ames City, Town, or Lum. 3c/f/more # Under 24 Hrs. B. Date of Birth Hours Min. Month, Dey, Year) 4b. City, Town, or Location of Deeth 4c. County of Death emori a 1705pita 12100 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 10M 20 F 80 Yrs. Months Days 2/1-18-7245 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location t0d. Inside City Limita 1 Tes 2 No 10e. Street and Number nore 10f. Zip Code 10g. Citizen of Whet Country? 2 130/102 120 14. Race - American Indian, 100 reet 12. Wes Decadent Ever in U,S. Armed Forces? 1 Yes 2 No 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Detes: 3 Widowed 4 Divorcad Blac 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Supervisor an17 2+4 7/4 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 0500000 PSCOm mes irdie 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Plecs of Disposition (Name of cemetery, cremetory or other plecs) Jaughter 20c. Location City or 20e. Method of Djeposition Dele Town, Stete 1 Buriel 2 Cremetion 3 Removal from State Zion 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensus 22. Name end Address of Fecility Doug 1955 uneral Service 1701 Me Culloh Street, Baltimore 23a. Part1. Enter the disease, of complications that caused the deal shock, or heart failure. List only one cause on earn line. Approximate interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Severe COPI Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 35LProbably 4 Unknown malautrition 24b. Were eutopsy findings sveilable prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 2 | No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation Injury 1 Nature 1 Yes 2 Accident

the buriel-transit end Records, P.O. Box 68760, physiclan ed by the a s been signed by I should be detact this certificate has Division of Vital Attending Physician: completaly filled in by the funeral After

death.

Hospital or Attendit 24 hours efter death. Funerel Director: A

To the Hospital within 24 hours e

Physician

/Medical

Director

by Funeral

Completed

Be

Examiner

Funeral

Director

7 is marked other than "natural", or Nems 23s or 28s-f show treumstic event, the Madical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after of Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Net any Injury or other treumatic event, the Medical Examina-

Physician /Medical

Examiner

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Maryland 21215-0020

Baltimore,

deeth with the Meryland

25. Was case referred to medical exeminer? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Sulcide

4 | Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es ateted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

6 Could not be determined

De

29c. License number

29d. Date signed (Month, Day, Year)

946 C12 August

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ricardo

Memorial Union

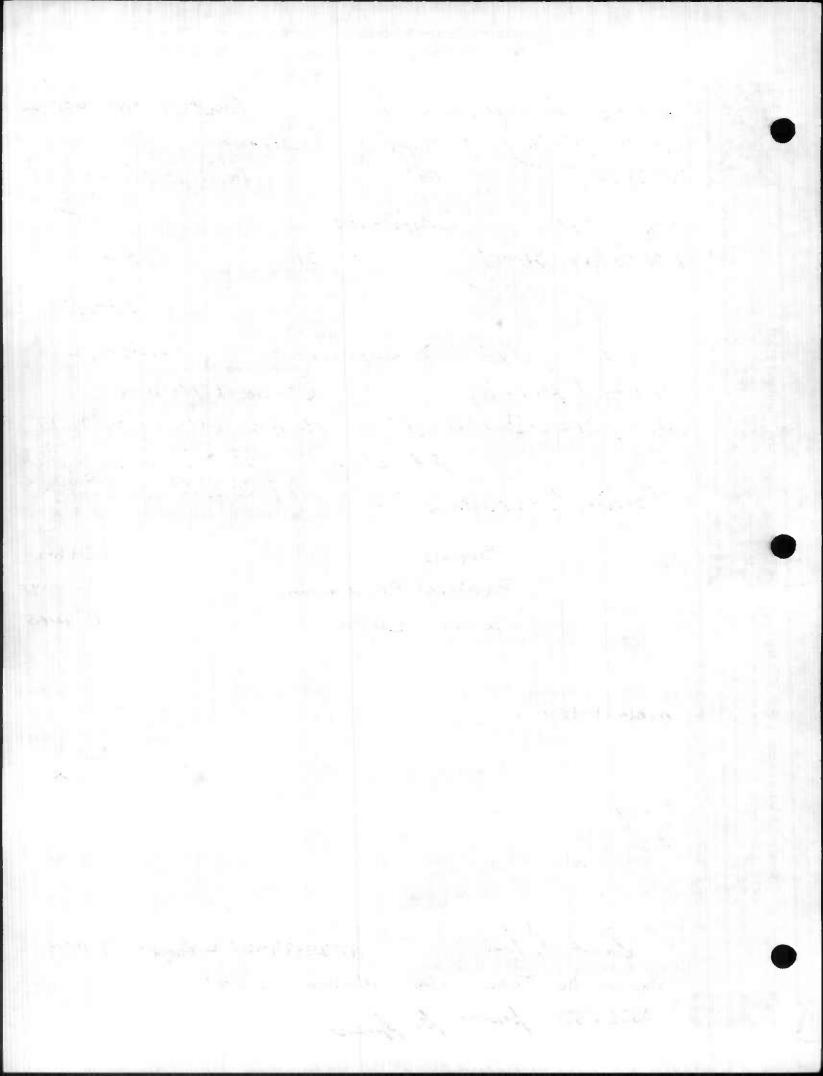
State Registrar

AUG 2 4 1999

32. Registrer's Signeture

Sesus

28e. Plece of Injury - Al home, ferm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month LORRINE ELIZABETH WENTZ MCLELLAN 4b. City, Town, or Location of Death 21 1999 4c. County of Deeth 10:50 AM 4a. Fecility Neme (If not institution, giva street and number) Saint Joseph Medical Center Towson Baltimore If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Hours Months 1 ☐ M 2 💢 F 82 217-64-2714 Dec 6, 1916 Maryland Usual Residence of Deceden 10e. Stete 10c. City, Town or Locetion 10b. County 10d. Inside City Limits 1 ☐ Yes 2√7 No Maryland Baltimore County Idlewvlde 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6210 Beechwood Road 21239 USA 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 12th Proprietor Delicatessen 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) John Walter Wentz Lillian Eva Wilhelmina Thomas 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 6210 Beechwood Road, Baltimore, MD 21239
ce of Disposition (Neme of Dete 20c. Location - City or Town, Stata Walter J. McLellan (Son) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Burial 2 Cramation 3 Removel from Stete 4 Donetion 5 Other (Specify) Dulaney Valley Mem. Grdns8/25/99 Timonium, Maryland of Funeral Serv 22. Nama and Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Maryland 21212 shock, or heart feiture. List only one ceuse on each line. Intervel Between Onset and Deeth Immediate Cause (Final METASTATIC ADENO CARCINOMA OF LUNG disease or condition resulting in deeth) 2 MONTHS Due to (or es a consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending Investigation

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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itsm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 and Mental Hyglena.
Is marked other than "na

permit. Pages 1 and 2 sh Department of Heelth end Important: If itam 27 is ms any Injury or other traum-

the Maryland

72 hours after deeth

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be ို Certification:

2 Accident

4 Homlcide

29b. Signatura and title of certifian

3 Suicida

29a. Certifier

Medical

buriel-transit and physician s the buriel Box 68760, 98 Records, P.O. signed by t peen page 2 certificate Division of Vital Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica こり To the Hospital within 24 hours e To the Funeral D

State Registrar **DHMH 16 Rev 6/95**

AN S 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

end manner stated.

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es stated.

Zi Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) 29c. License number

1 ☐ Yes 2 ☐ No

D 37254

29d. Date signed (Month, Day, Year)

28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

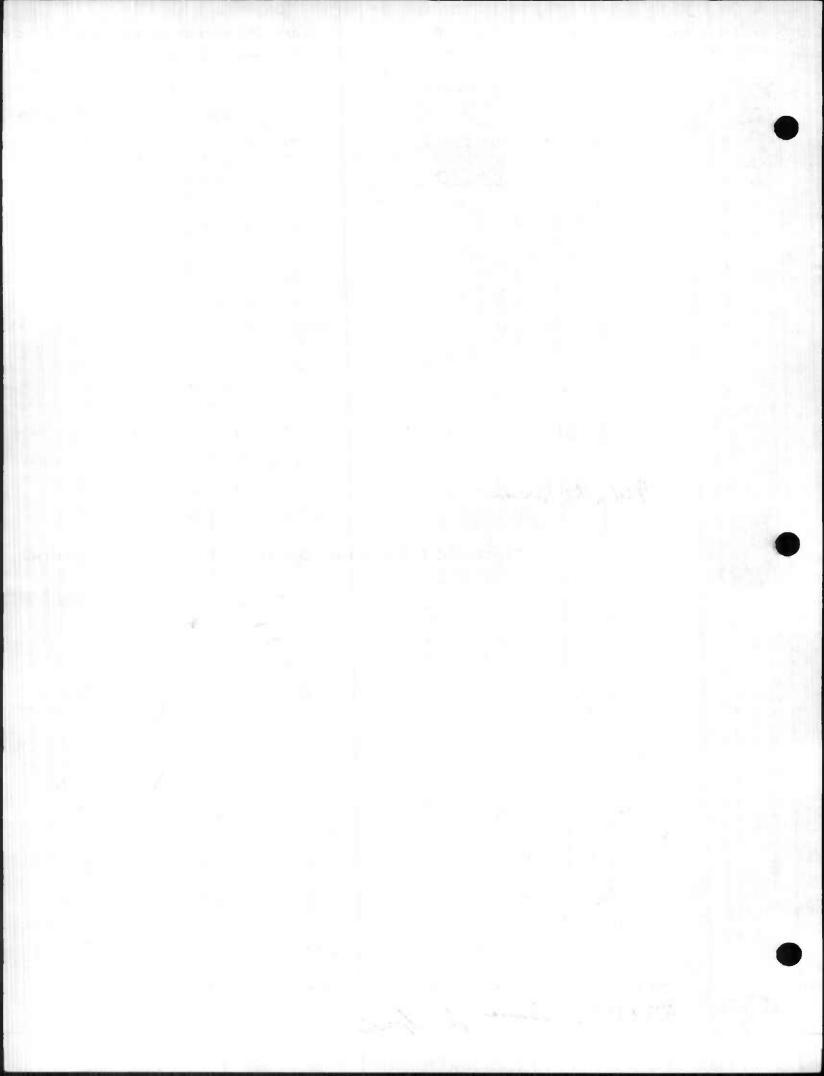
BOON P. LIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Dey, Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrer'e Signature AUG 2 4 1999

6 Could not be determined

Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Name (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Year Month **Physician** MARY GERTRUDE MUTH 23 1999 August 9:45 am /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 24 Hrs. If Under 1 Year Birthplaca (State or Foreign Country) 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□ M 2XXF Deys Hours 220-30-0008 Yrs. Director 90 July 2, 1909 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 Yes Y No 288-71 Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 늄 b Examiner must be 2300 Dulaney Valley Road Name 23a 21093 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes XX No
ff Yes, Give
Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. XX Nevar Married 2 Merried 'natural', or Baltimore, Maryland 21215-0020 1 Yes XXXVo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry filed within then Elementery/Secondary (0-12) College (1-4or 5+) Secretary Church 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) 98 permit. Pages 1 and 2 should be Department of Health and Mental. Important. If Item 27 is market any Injury. 2 should be I and Mental P Edward Sebastian Muth Anna Gertrude Arning 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L Muth Jr Nephew 5401 Loch Raven Blvd. Baltimore, Maryland 21239 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1XXBurlal 2 Cremetion 3 Removal from Stete New Cathedral 8/25/99 | Baltimore, Maryland □ Donetion 5 □ Other (Specify) ignature of Funeral Sarvice Licenses 22. Neme end Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. 23a, Part. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset end Deeth **Physician** /Medical immediete Cause (Finel disaese or condition resulting in deeth) a. DEMENTIA Examiner Due to (or as a consequence of): ANEMIA burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760. attending physician for use as the bune DIABETES 90 Physician/Medical certificate Due to (or as a consequence of): P.O. signed by the i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown Records. by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed peen page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After Division 1XXVeturel Attending 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendition 24 hours after death.
To the Funeral Director: A completely filled in by the forms investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homloide Control Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. edicai 29e. Certifier (Check only one) Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b, Signature 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Makhuda, 2300 Dulaney Valley Rd Timonium, Md 21293 M.D. 31. Date filed (Month, Day, Year) AUG 2 4 1999 32 Begistrer's Agneture State

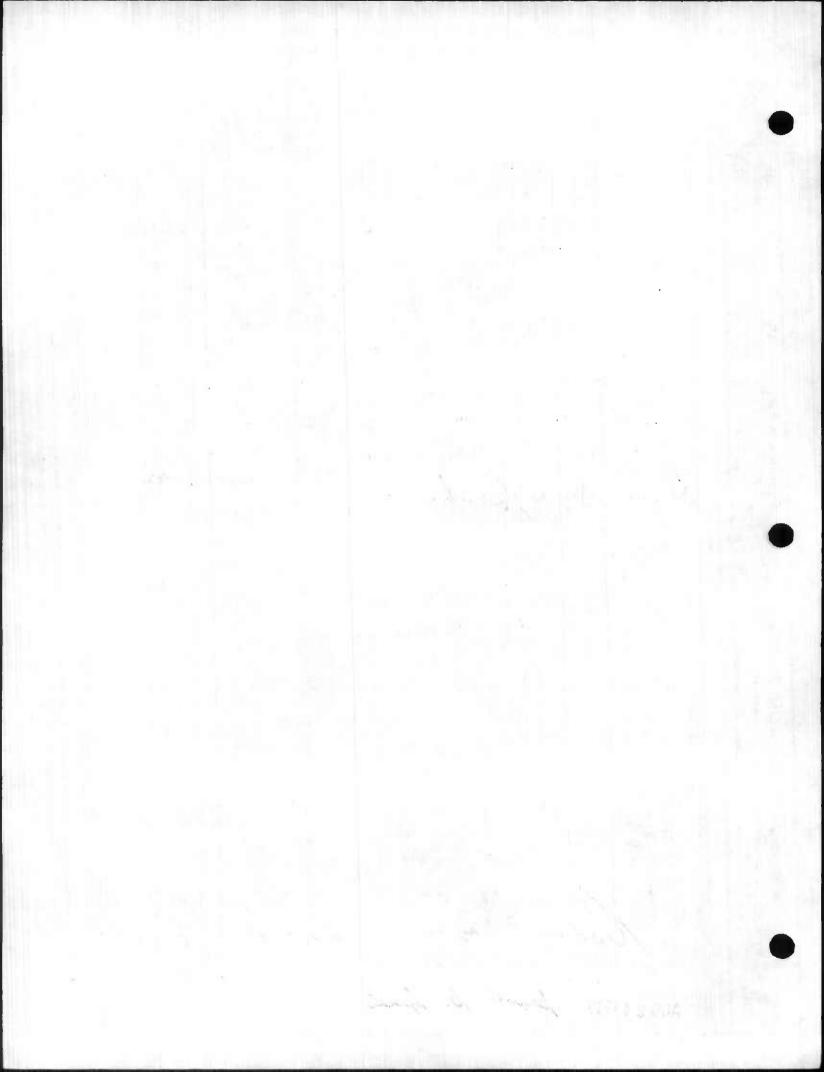
GERTRUDE MUTH

RY

MA

DHMH 16 Rev 6/95

Registrar



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State of Maryland / Department of Health and Mental Hygiene

				Cert	tificate of	Death	F	Reg. No. 9	265	71			
	Physician /Medica	CCA CIGO	PALL	MOSE	25		2. Data of Dea Month		Xear 3. T	ima of Deeth			
	Examine	As Franklin Manney (Mannet Innelling allers and	11.011.	s Hosp	ital	Balt	Location of Death	4c. County	of Death N/A				
	Funeral Director	220.84 1003	7. Age (1)	In yrs. last birthday	ff Under 1 Yaar Months Deys			(Vear)	9. Birthplace (S Country)	State or Foreign			
Maryland f ahow	Manyland -f ahow	Usual Residence of Decedent 10a. Stata 10b. County BALTIM		Oc. City, Town or Loc				10d. fnside City Limits. 1 ☐ Yes 2 🗹 No					
	vith the Mer t or 28s-f si be notified	10e. Street and Number 10f. Zip Code 10g. Citize											
5-0020	th with	1720 SEVERN TI	REE COWET		2114	4		U:	34				
	72 hours after death with the Maryland natural, or items 23 or 28-1 show stell Examiner must be notified at the Hyperesis Directors.		12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		as Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Bled Specify	e - American Ind ck, White, etc.	en,			
	"natural",			16a. Decede	ent's Usuel Occu	pation	utring	16b. Kind of Bu	usiness/Industry				
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Maryland	Main H	17. Fethar's Name (First, Middle, Last)	3			0	ma (First, Middle, MAELIN	Maiden Suman	70)				
lan	d 2 should h and Men 7 la marke traumatic	19a. Informant's Name/Relationship	Type, Print)	19b. Malling	Addrass (Stree	t and Number or R		r, City or Town,	State, Zip Code				
3, 6	an and and and and and and and and and a	PAMELA MOSES	WIFE		EVERN .	TREE G	1	AUSTOWN		21144			
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Baltimor	Semit. Pag Separtment mportant: h any Injury o	4 Donation 5 Other (Specify		MEADOW RID			8.26.99	ELKRIA	GE, MI)			
Bal	permit. Pages Department of Important: If I any Injury or once.	21. Signature of Funeral Sarvice Licensee 22. Neme and Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PLVE, BALTO. MD. 21229											
	Physician	23a. Part1. Ent allo disaasa, or corn shock, or hand failure. List only	olications that caused the	e death. Do not entai	the mode of dy	ing, such as cardia	c or respiratory an	rest,	Appro	oximata al Between t end Deeth			
	/Medical Examiner	Immediate Cause (Final disease or condition resulting to death)		LESPIRATOR		TRESS S	YNDROM	=	6	WEEKS			
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	avacuted in and instransit	Sequentially list conditions.	0.	a to (or as a consequ		10 17 011				MANTHS			
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R	The law ate has page 2						121	es 2 No	1 Tes	22 No			
Vital	certificate rector, pag					26. Place of De	eth (Check only o	ne)	1	•			
of V	S Sig		Hospital: 12 tnpatient	2 ER/Outpatient	3 DOA	ther: 4 Nursing I	Home 5 Resid	lence 6 Oth	ar (Specify)				
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Division	F = 5 E	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number of City or Town, State)							per or Rural Rout	Number,			
	To the Hospital or within 24 hours after To the Funeral Dir. completaly filled in Medical Cert		sician: To the best of miner: On the basis of ex and manner stated	amination and/or inva	occurred et the t estigation, in my	ime, dete end place opinion, death occ	e, and due to the durred at the time, d	cause(s) and ma date end place,	annar as stated. and dua to the c	nuse(s)			
	To within to To the Comp	29b. Signature end title of certifier	Euser, M.	>		S - 000			d (Month, Day,) + 20, 1				
		30. Name and address of person who of FRANCES R. Jansa			rint)	L BALT							

State Registrar

31. Date lited (Month, Day, Year) AUG 24 1999

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Service S. Free Dept 18 2010

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Moh homas 01:45 Am Husust 21 1999 4b. City, Town, or Location of Death · /Medical 4c. County of Death 4a Facility Name (If not Institution, give street and number, Examiner Balt Administration n/a Veterans 11,more If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 12 M 20 F Months Days 8 Yrs 226-18-2567 April 21,1921 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5972 Elk Forest Court 21075 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 1948-50 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Contractor Home Improvement 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Mohler Rena Belle Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Gavin/Daughter 5972 Elk Forest Court Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 8/24/99 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Fun. Home @ Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, MD 21075 discusse, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, lastice. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) FIOrosis monery Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco uea contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed PE No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

Division of Vital Records, P.O. Box 68760 or Attending Physician: deeth. after deeth Director: To the Hospital or within 24 hours at To the Funeral D

Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other treumetic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "American any injury or other transmissions."

Physician /Medical

Examiner

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this funeral

with the Maryland

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) AUG 2 4 1999

1430A

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

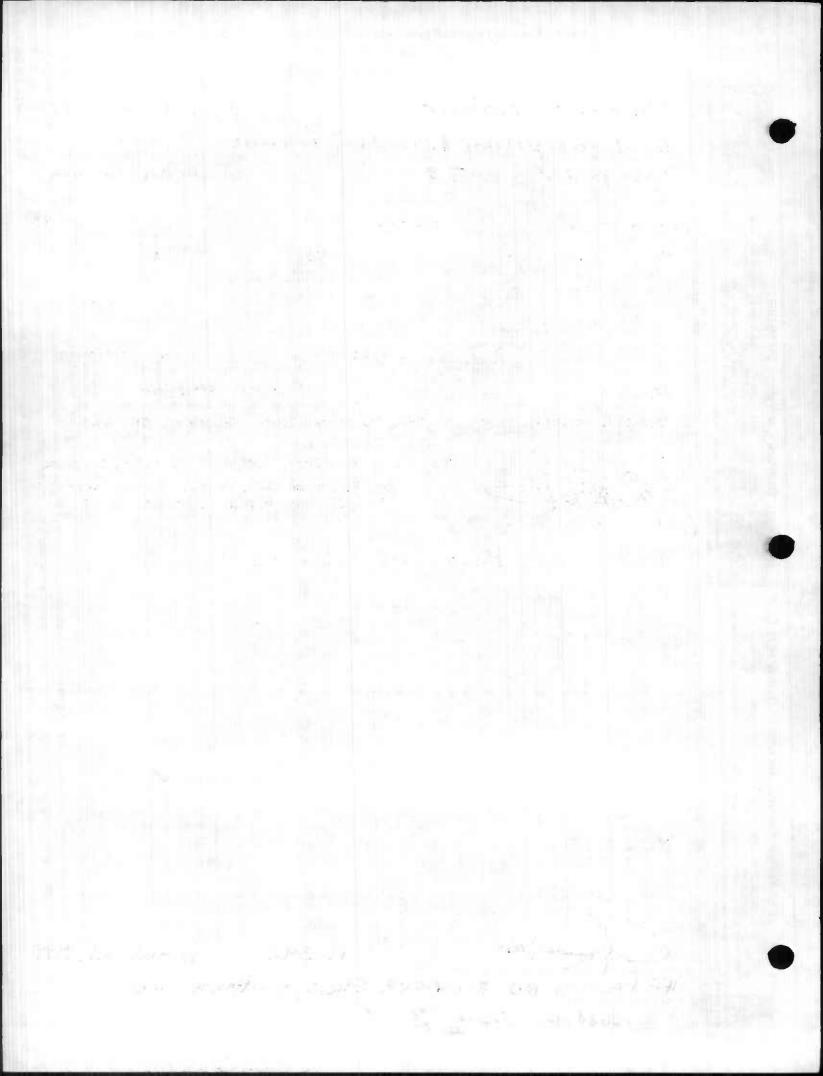
29b. Signature and

32. Registrar's Signature

street, Baltimore

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year 130P.M. 4b. City, Town, or Location of Death 1999 4a. Facility Name (If not institution, give street end number, 4c. County of Death Gilmore 6426 E 5. Social Security Number H Under 1 Year | H Under 24 Hrs. | 8. Date Balto 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) 1 M 2□F Days 0 216-50-0048 Usual Residence of Decedent Yrs. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Balto 1 ☐ Yes 2 No Wood lawy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2120 (91/more 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Dates: 11. Marifel Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2D No Specify. 3 ☐ Widowed 4 ☐ Divorcad Black 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Nongshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Rosa Claude Lea hee 19a, Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Gilmore Peronica Woodlawn, Md Mitchell wite 6426 20b. Placa of Disposition (Neme of cometery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Kandal/stown, Md 4 ☐ Donefion 5 ☐ Other (Specify) 26/99 21. Signature of Funeral Servica Licensee 22. Name and Address of Fa 23e. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 2/2/5 Approximate Intervel Between Onset end Death Immediate Cause (Final zyrs disease or condition resulting in death) Severe 3 mouths Sequentially llst conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth Date of Injury (Month, Day Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

The law requires that the death cartificate be executed the burial-transit Box 68760 for usa as P.O. I signed t Records, page 2 should certificate has of Vital or Attending Physician: After this illed in by the funeral Division death. after death

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

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Director

Funeral

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permit. Peges 1 and Depertment of Health Important: If item 27 any injury or other tr

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

2 Accident 3 ☐ Suicide 4 I Homicide

6 Could not be

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated. 296 Signature and title of certifie

29c. License number

28e. Placa of Injury - At home, farm, streef, factory, office building, etc. (Specify)

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) libert

32. Registrar's Signature

Hauts Bultimore

State Registrar

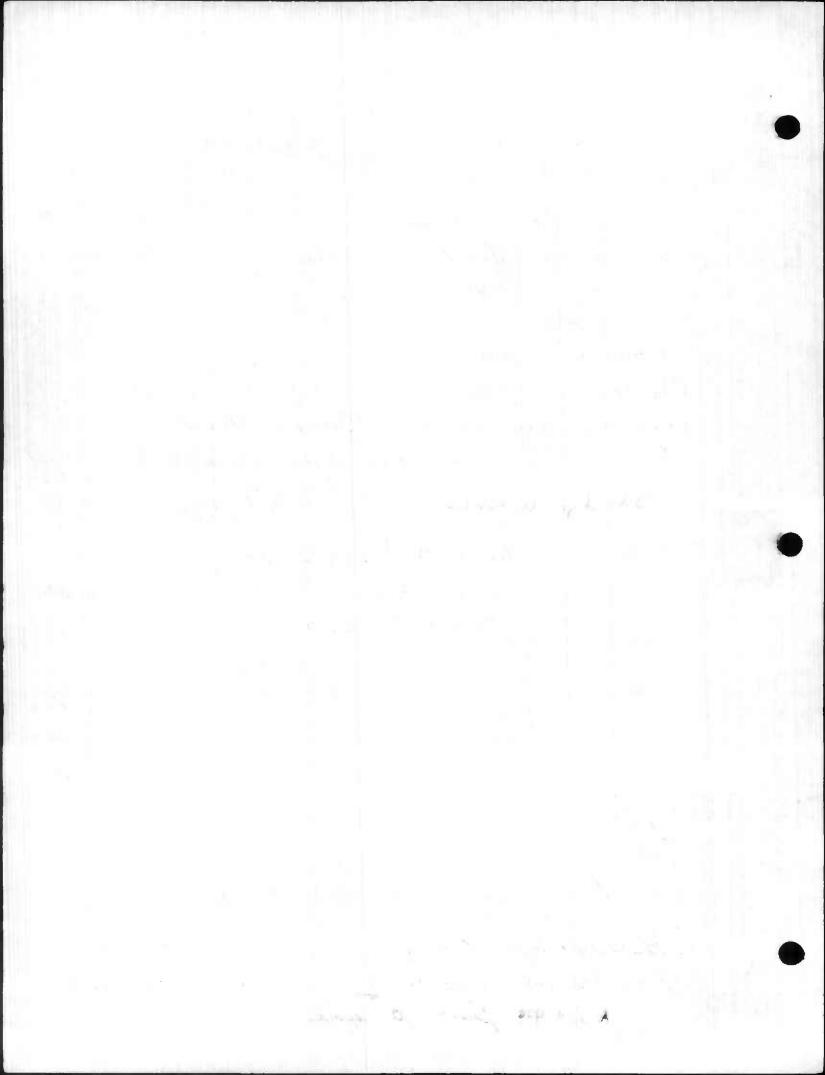
31. Date filed (Month, Day, Yeer) AUG 2 4 1999

within 24 hours To the Funeral

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Medical

29a. Certifier (Check only



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00

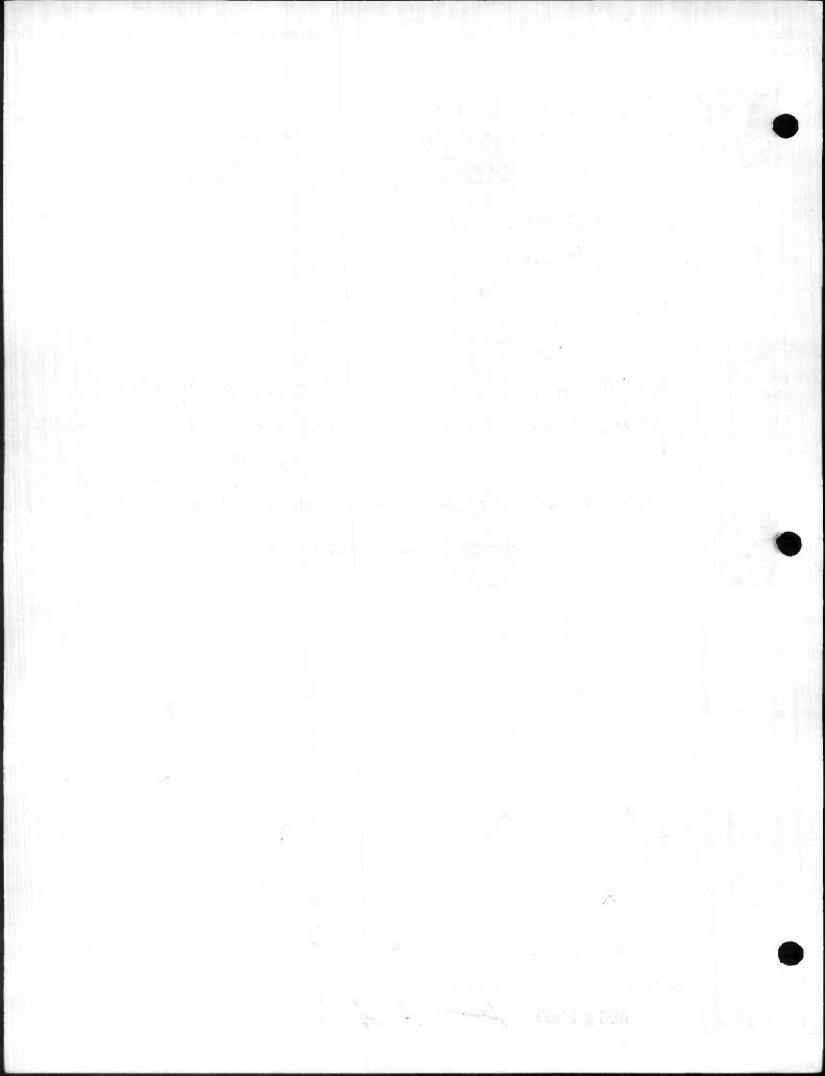
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	Funeral Director		5. Social Security Number 6. Security S	7. Age (In yrs. le	Yrs. If Und Month	der 1 Year is Days		8. Date of Birth (Month, Day,	10(10)	9. Birthpl	lece (State or Foreign
	yland		10a. State 10b. County	10c. City	, Town or Location					10	Od. Inside City Limits
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	deeth	Funeral Director	11. Marital Status	12. Was Decedent Ever in U,S	6. 13. Was Dec	cedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-		a - America	
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any follury or other traumatic event, the Mexical Examinating must be notified at angles.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □ Yes	2 No	Specify:		Specify	ik, White, e	lite
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pue	be file htal Hy d oth	Be	17. Father's Name (First, Middle, Last)	4			18. Mother's Nem	e (First, Middle, M	Maiden Surnam	0:0	
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OUO	Attending Physician: or deeth. ector: After this certific by the funeral director,	tion:	27. Manner of Death 1. Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Inju Wo	ryat rk?]Yes 2 □ No	28d. Describe ho	w injury occurr	ed	
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	To the complete compl	Σ	29b. Signature and title of certifier	N I O			se number		d. Date signed		•
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			30. Name and address of person who cor NATIVIDAD D. DE			LER	DRIVE TO	OWSON M	IARYLA	ND S	1204
			31 Date filed (Month Day Year)	On Desistant Circum							

Registrar

AUG 2 4 1999

32. Registrar's Signature

6. Aparls.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 57E 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Year 3:20 AM tuaust MARIAN RENA MYERS 4c. County of Dee 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death bita Baltimore ranklin square 405 ose dale If Under 24 Hrs. 8. Dete of Birth (Month, Day) DEC 12 If Under 1 Yee Social Security Number 6. Sex Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign Devs Months 1 M 200 F RHODE ISLAND 218-03-1138 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2000 MARYLAND BALTIMORE WHITE MARSH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 LORLEY ROAD 21162 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 11 Meritel Stetus 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify Specify: BLACK 3 X Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC 11th grade HOUSEWIFE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) **CEPHAS** JOHNSON RENA **JOHNSON** 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13364 Warwick Spring Dr. Newport News, VA Thomas Myers/Son 20b. Pleca of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 Surial 2 □ Cremetion 3 □ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8-21-99 WHITE MARSH, MARYLAND ASBURY CHURCH CEMETERY 21. Signeture of Funeral Service Licent 22. Name end Address of Fecilit WILLIAM C BROWN COMMUNITY FUNERAL HOME-ABERDEEN S PHILADELPHIA BLVD ABERDEEN MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death · Posterior Circulation Immediate Ceuse (Final disease or condition resulting in death) Injarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturai 5 ☐ Pending 1 Tyes 2 □ No investigetion 2 Accident

that the death certificate be assecuted **burial-transit** Box 68760 physician the P.O. been signed by the s should be detached Records, The law requires page 2 certificate Division of Vital Hospital or Attending Physician: this After

death.

24 hours after deat Puneral Director:

within 2 To the

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Examiner Physician/Medical þ Completed Be Medical Certification: To

Physician

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r then "natural", or heme 23s or 28s-f show the Medical Examiner must be notified at

traumatic

: If Hem 27 is n

permit. Page Department of Important: If any Injury or once.

Physician

Examiner

/Medical

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death with the Maryland

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within Health and Mental Hygiene.

> 29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated [Description of the cause of the c Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture and thin

29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of deeth (Item 23a) (Type, Print) 30. Neme and addr

6 Could not be determined

Square Drive Baltimore, Maryland

9000 Franklin efa

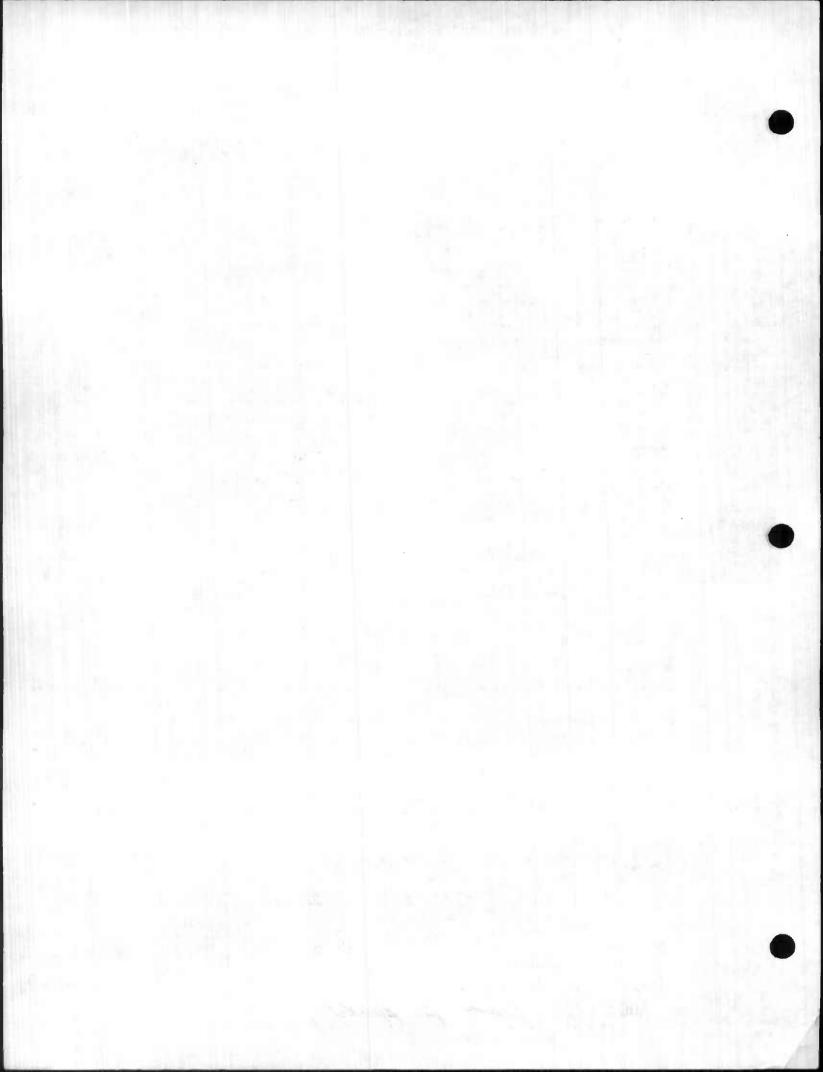
2 4 1999 AUG 2

32. Registrer's Signeture

28e. Pleca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

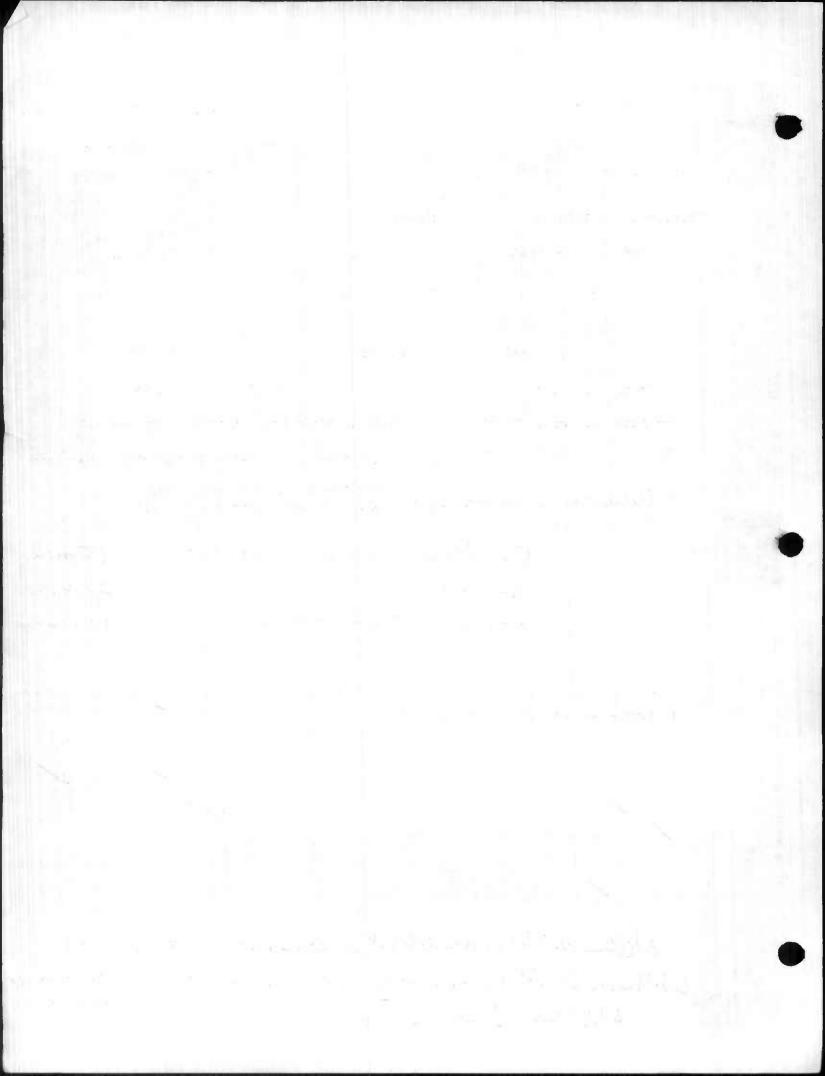
State Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

		Certifica	ite of D	eath		Reg. No.		200/6
Physic	cian	1. Decedant's Nama (First, Middle, Last)			2. Date of De Month	Day	Yaar	3. Time of Death
/Med		James Milton Noble	46	City Town as I	Augus		1999	7:35 A.M
Exam	iner	4a. Facility Nama (If not institution, give street and number)	40	. City, Town, or Lo	ocation of Deat	4c. Coun	ity of Death	
		Blakehurst 5. Social Sacurity Numbar 6. Sex 7. Aga (In yrs. last birthday) If Und	ar 1 Year	TOWSON If Undar 24 Hrs.	8. Data of Bir	В	altim	
Funera Director	_	215-03-0207 1 Month Usual Residence of Decadent	s Days	Hours Min.	(Month, Da 4-14-	y, Year)	_	piace (State or Foralgentry) ryland
and w		10a. Stata 10b. County 10c. City, Town or Location	-					10d. insida City Limits
e Mary	ctor	Maryland Baltimore Towson						1 Yas 2 No
th with th	ai Director	10e. Street and Number 1055 W. Joppa Road	ip Coda 21204			10g. Citizan o	f What Cou S. A.	ntry?
be filed within 72 hours effer deeth with the Maryland ital Hygiene. Id other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Navar Marriad 2 Marriad 1 Vas 2 No	edant of His ecify Cuban 2⊠ No	panic Origin? (Sp , Maxican, Puerto Specify:	ecify Yas or No Rican, etc.)	14. Ra Bi	ace - Americack, Whita, hify: Wh:	atc.
within 72 ho iene. then "netu	Completed	15. Decedant's Education (Spacify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Treasul	vork done du use ratired)	lon ining most of work	ing	16b. Kind of		dustry
filed v Hygie other t	ပိ	17. Fethar's Nama (First, Middle, Last)		18. Mother's Name	n /Finnk Adiabatio			
ould be f Mental F arked of	Be		'				. '	
should be id Menta marked matic ev	2	James F. Noble 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addra		Ethe		Bunt:		0.11
d2s han 7 le r								
Tan Heeli Fm 2		Mrs Anna E. Noble (Wife) 1055 20a. Mathod of Disposition (A		ppa Road	Data	20c. Location		
Peges net of nt: If its		1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Parkwood Cer	other placa,		8-23-99			, Marylan
permit. Pages 1 and 2 should be Department of Heelih and Mente Important: If Item 27 is marked eny injury or other traumstic engles.		Milallan C Banka Ruch		on Funer				
_		23a. Pert1. Entar tha disaese, or complications that caused the daath. Do not antar tha mishock, or haart failura. List only ona causa on eech iina.	York	Road, T	OWSOn ,	Md. 2	1204	Approximete
Physician /Medical Examiner					rres			interval Between Onsat and Death
	ē	immedieta Causa (Final disease or condition resulting in death) a. Cardio pulmo pue to (or as e consequence of the consequence	f):	ı				15 min
d d ensit	Examiner	Sequentially list conditions. Dua to (or as a consequence of					- 1	>0 14 1-
exec an en riel-tr	EX	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or Injury that initiated evants		1 tian				10 - 000
h certificate be executed anding physician end use es the buriel-trensit	n/Medical	Causa (Disease or Injury that initiated evants resulting in death) Last C. Dua to (or as a consequence of d						, , ,
the ette	sicie	Pert ii. Other algnificant conditions contributing to death but not resulting in the underlying	causa giver	n in Part i.	23b. Did	tobacco usa c	ontributa t	o the cause of deat
ires that the death cer signed by the ettendir id be detached for use	by Physician/M	Congestive Heart Failure				Yas 2 No		bably 4 Unknow
nous shou	Completed b				24e. Was	an autopsy ormed?	av	ara autopsy findings vailabla prior to emplation of cause death?
	FO				10	Yas 2 No	1	□Yas 20 No
lan: artific ctor,	Be (25. Was case rafarred to medical axaminar?		26. Plece of Deet	h (Check only	ona)		
nysic li dire	To	1 Yas 2 No Hospitei: 1 Inpatient 2 ER/Outpetient 3 I	OOA Othar	4 ☐ Nursing Ho	me 5 Desi	dance 8 🗆 O	thar (Speci	(fy)
Attending Physician: ir death. ector: After this certific by the funeral director,		27. Manner of Deeth 1 Naturel 5 Panding (Month, Day Year) 2 Accident Invastigation 28a. Date of Injury (Month, Day Year) M	28c. Injury e Work? 1 ☐ Ye	es 2 No	28d. Dascribe	how injury occu	urred	
	Certification:	3 Suicida 6 Could not ba datarmined 28a. Place of injury - At home, farm, street, facto building, atc. (Specify)			City or To	wn, Stete)		al Routa Number,
To the Hospital or within 24 hours effer To the Funeral Director completely filled in	edicai	29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledga, death occurre on the basis of axaminetion and/or invastigate and mannar stated.	d at the tima on, In my opin	, data and place, nlon, death occurr	and dua to tha red at tha tima,	causa(s) and r data end plece	mannar as s e, and due t	stated. o the cause(s)
To th Withir To th	Me	29b. Signatura and title of certifiar Mulonulm	9c. License	numbar)4213	29	29d. Data sign	ad (Month,	Day, Year)
3/1		30. Name and eddrass of parson who complated causa of daath (Item 23a) (Type, Print)	50	0 W, (uni			Baltin
St	tate	31. Date filed (Month, Day, Yaar) 32. Registrar's Signature					10	Balton 21210



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

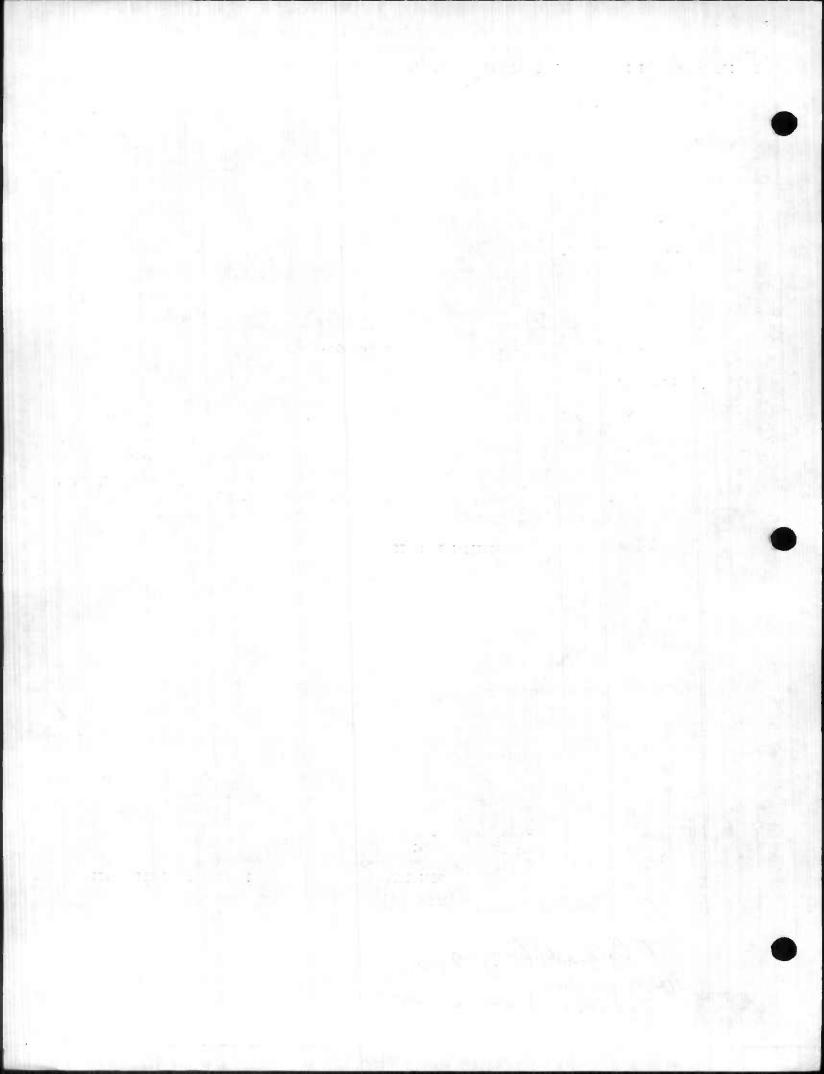
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State of Maryland / Department of Health and Mental Hygiene

O

			Centi	ificate of	Doutin		Reg. No.		
ian	1. Decedent's Neme (First, Middle, Li		n			2. Dete of De Month	Dey	Yeer 3. T	ima of Death
ical	4e. Fecility Neme (If not Institution, gi		, ,		Ab Ciby Town o	r Location of Deet	h 4c. County	999 3	. 101
ner	Stella Mari	s Kispice			BALTIA			Horor	
	5. Sociel Security Number 6.	Sex 7. Age (In yr.		If Under 1 Yee	If Under 24 Hi	s. 8. Dete of Bir	10 10 1	O Dishalass /	Stete or Fore
0	2/7-26-032/ Usuei Residence of Decedent	10 M 20 F 90	Yrs.	Months Deys	Hours Mi	n. (Month, De	15/1909	CEDIGI	
	10a. Stete 10b. County		City, Town or Locat		,			10d. Ins	side City Lim
ctor	Marylono BAIT	nur	KAND	pollsh	un			118	Tres 201
Funeral Directo	10e. Steet end Number 8629 LUCE	RNG BAD		10f. Zip Code	1133		10g. Citizen of V	40	
ner	11. Marital Stetus	12. Wes Decedent Ever In Armed Forces?	U,S. 13. Wa	s Decedent of	Hispenic Orlgin?	(Specify Yes or No erto Rican, etc.))- 14. Rec	e - American Ind	lien,
by	1 Never Merried 2 Merried	1 Yes 2 No If Yes, Give Yeer or Dates:		Yes 2011		nto ritoan, otc.)	Specify	ck, White, etc.	
eted	15. Decedent's E (Specify only highest gr	ducation	16a. Deceden	nt's Usuel Occu	pation	orkina	16b. Kind of Bu	usiness/Industry	
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		NOT use retire	during most of weed)	Orking	Prive	te for	ly
o Be C	17. Fether's Name (First, Middle, Last				18. Mother's N	ame (First, Middle	, Meiden Sumam	10)	
-	19e. Informent's Name/Reletionship		19b. Mailing A	Address (Stree	at end Number or I	Rural Route Numb	er, City or Town,	Stete, Zip Code,) ,
	+7040 Simmon	(/50n	_			RUMO ,	-	0 4 1	/ /
	20e Method of Disposition	20b.	Place of Dispositi	ion (Neme of	ace)	Dete /		City or Town, St	
	Buriel 2 Cremetion 3 C	THemover from State	contou,	~		8/25/99	Woun	cour,	man
	21. Signeture of Funerel Service Lice	9-	22. N	leme end Addr	ess of Fecility	WATE	m-1		ZH
	I do de		50	40 92	U (TEXS	hun L	UAN		
	23e. Pert1. Enter the disease, or com	plications thet caused the de	ath. Do not enter t	the mode of dy	ing, such es cardi	ac or respiretory e	rrest.	Appro	oximate
	shock, or heert faflure. List only	one ceuse on eech line.						Interv	t and Deeth
	Immediate Ceuse (Finel	CONCECUTATE	TIPADE IIA	TITTOR				į	
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ne		-	(5, 55 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5					1	
Examiner		b. ————							
1.81	Sequentially list conditions,	Due to	(or es e consequer	nce of):					
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edicai	thet initieted events	cDue to							
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by Physician/Medical	resulting in death) Lest	c	or es a consequer	nce of):	iven in Pert I.	1□	Yas 2□ No	3 Probably	4 ▼ Unkn
by Physician/Medical	resulting in death) Lest	c	or es a consequer	nce of):	iven in Pert I.	1 D		3 Probably 24b. Were aut	4X Unkn
by Physician/Medical	resulting in death) Lest	c	or es a consequer	nce of):	iven In Pert I.	1 D	Yas 2□ No an autopsy primed?	3 Probably 24b. Were aut	Unkr
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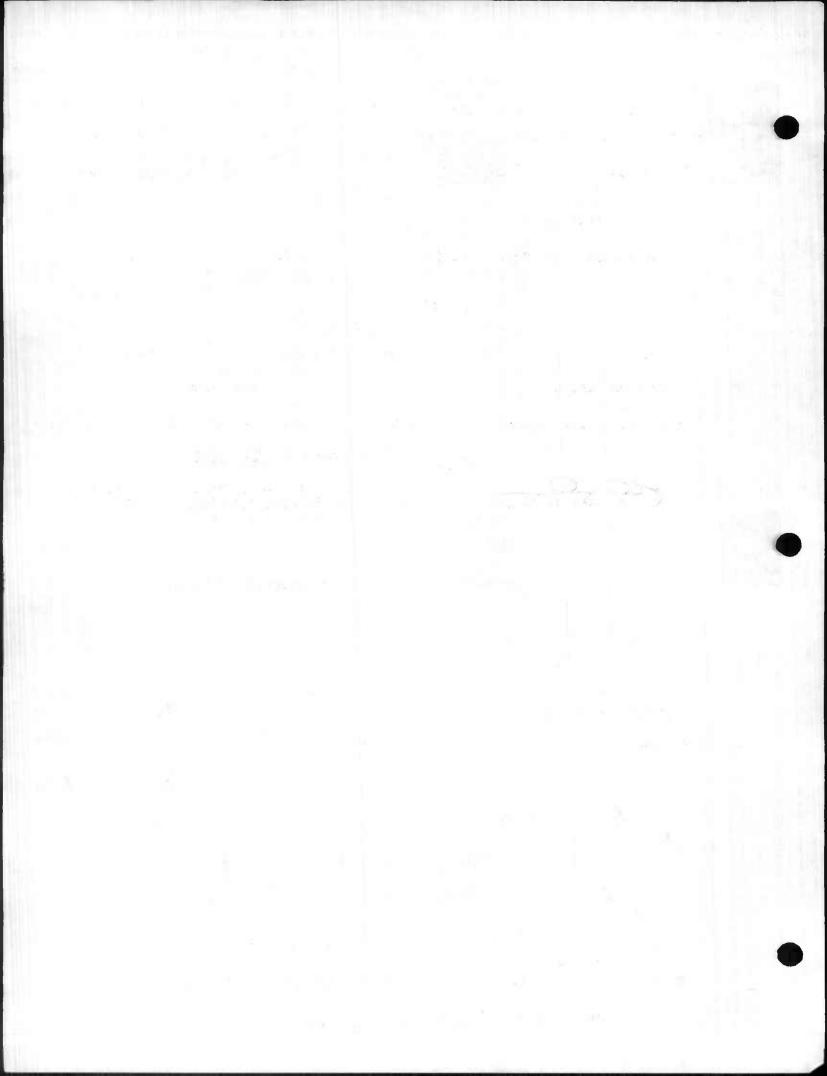
Sherman No: AMEND ITEMS	rton : #23 PART I, 27, 28A-F	State of Maryland PER MEO G774 8-25	d / Depa	artment of H	lealth and Death	d Mental Hy	rgiene Reg. No. 9 9	2	° - 40
Physiciar	Decedent's Neme (First, Middle, Language) CHERMAN, T. NORTH	**				2. Dete of Do Month	Day	Year	3. Time of Death
/Medica Examine	SHERMAN J. NORT			4	b. City, Town,	Augus or Location of Dear		of Death	7:20 A.M.
Examine	1905 Mosher Stre				Balti	more		N/A	
Funeral Director	217-68-4723	Sex 7. Age (In yrs. 1		If Under 1 Yeer Months Deys	If Under 24 I Hours A	Ain. 8. Date of Bi	rth av. Year)	9. Birthpl Count	lace (State or Foreign try) MD.
D Bu	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City	y, Town or Lo	cation				10	0d. fnside City Limits
Mary Bet sh	MD. N/A	BA	LTIMOR	E					NO Yes 2□No
) free death with the Ma free revet be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	lry?
eath v	1905 MOSHER ST.	12. Was Decedent Ever in U,	S 13 V	21217		(Specify Yes or N	USA	e - America	an Indien.
5-0020 72 hours after death with the Maryland natural; or thems 23a or 28a-f show sidest Examiner must be notified at	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		Yes, specify Cube		? (Specify Yes or Nuerto Rican, etc.)	Specif	ck, White, e	etc.
Maryland 21215-0020 at 2 should be find within 72 hours at its and Mental Hygiens. 77 is marked other than "natural, or traumatic event, the Medical Exam.	15. Decedent's E(Specify only highest gr	ducation ade completed) College (1-4or 5+)	(Give	lent's Usuel Occup kind of work done o OO NOT use retired KLIFT OPE	during most of ()	working	16b. Kind of B		
land 2 id be filed ental Hygie kad other ic event, it	17. Father's Neme (First, Middle, Last		Tota	REITT OT	18. Mother's	Neme (First, Middle OTHY NORT	, Maiden Sumen		N
	19a. tnforment's Neme/Reletionship DOROTHY NORTON (M	(Type, Print) OTHER)	19b. Mailin 1905	MOSHER S	T. BAL	r Rurel Route Numb	ber, City or Town, IARYLAND	Stete, Zip	Code) 7
Baitimore, Romit. Pages 1 and Department of Health Proportant: if them 27 and injury or other 2 and 8.	20e. Method of Disposition KXBuriel 2 Cremetion 3 C 4 Donation 5 Other (Speci	Removal from Stete	emetery, crem	sition (Neme of netory or other plea EMORIAL P		Dete 8-24-99	20c. Location BALTIMOI		
Balti permit. Departm imports any inju	21. Signature of Funerel Service Lice		1	Name and Address		PHILLIPS ST. BALT	FUNERAL	HOME	, P.A.
Physician	23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	nplications thet caused the deeth one ceuse on each line.							Approximate Intervel Between Onset and Deeth
/Medical Examiner	immediate Ceuse (Finel disease or condition resulting in death)	NARCOTIC INT	OXICATIO	N					
		Due to (or	r es e conseq	uenca of):				1	
8760, ate be executed thysician and the bural-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ——— Due to (or	r es a conseq	uence of):					
death certificate be expected to extending physician and for use as the burial stranger of the control of the c	Ceuse (Disease or injury thet initiated events resulting In deeth) Last	cDue to (or	es e consequ	uenca of):					
death certification of for use a	Pert II. Other significant conditions	contributing to death but not resu	ulting in the un	dedving cause giv	en in Part I	23b Did	tobacco usa co	ntributs to	the cause of death?
P.O. d by the detached by the		on the second section sections and the second section	ming in the di	out of give	on mit (ai) 1.		Yes 2 No	3 Prob	1.4
Too requirements							s an eutopsy ormed?	CON	ere autopsy findings nilable prior to mpletion of cause death?
The law ate has to page 2 s						16	Yes 2□No	次	Yes 2□ No
of Vital F Physician: The this certificate rial director, page	25. Wes case referred to medical examiner?	Hospitel:		Oth	07.	Deeth (Check only			
Physic wrthis co		28a. Dete of Injury	ER/Outpatien 28b. Time of	A 28c. Injun	4 LI Nursin	g Home 5 Res 28d. Describe	how injury occur		')
Vision Attending I or death. ector: Atter by the fune	1 □ Netural 5 □ Pending investigetio	" 8_18_00	FOUND?		Yes 2XXNo	UNKNO	NMN		
5 5 5 5 E	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At ho building, etc. (Specify	me, ferm, stre			City or To	(Street end Numb own, Stete) HER STREE		I Route Number, IIMORE, MD.
To the Hospital within 24 hours To the Funeral completely filled		nysician: To the best of my knowniner: On the basis of examinet end menner steted.	vledge, deeth ion end/or inv	occurred et the tin restigation, in my o	ne, date and pl pinion, deeth o	ace, end due to the ccurred et the time	cause(s) end m , dete end place,	enner as st and due to	ated. the cause(s)
To the comple	29b. Signature and title of certifier	111		29c. Licens	e number		29d. Date signe	d (Month, I	Day, Year)
	Theody	Uke of rus		0.	C.M.E.		August	19, 1	1999
	30. Name and address of person who	completed cause of death (Item	,13	ll Penn S	treet.	Baltimor	e, Marvl	and 2	21201
State	31. Date filed (Month, Dey, Year)	32. Begistrer's Stinet	ture spa	Ms					
Registrar	AUG 2 4 1999	1							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Deta of Deeth **Physician** Day 0 1999 9:00 FM AUGUST Nob1e Mary A1ma /Medical 4a. Fecility Neme (If not institution, give street end number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Deeth
Baltimore Examiner Towson If Under 1 Yeer if Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) March 26, 1920 Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2 F Months Deys 79 Yrs. 212-12-4937 Director Maryland Usuei Residance of Dacedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits **ehow** 7 is marked other than "natural", or items 23s or 28s-f shor traumetic event, the Modical Examenal must be notified at 1 Yas 2 No Director Baltimore Towson 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 106 Kenilworth Park Drive Apt. 2A 21204 USA Funeral 12. Was Dacedanf Ever In U.S. Armed Forcas? 1 ≦ Yes 2 □ No If Yes, Give Yaer or Detes: 42 1 -45 1 Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter o Department of Health and Mental Hygiene. Introchant: if Item 27 is marked other than "natural, or item only injury or other traumatic event, the Medical Expenses once." 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 15. Dacedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 4 Registered Nurse Medical 17. Fether's Nema (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maiden Sumeme) Charles Chlan Matilda Schultz 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 106 Kenilworth Park Drive Apt. 2A Towson, Md 21204 Alvin H. Noble/ Husband 20b. Piece of Disposition (Nema of cometery, crematory or other place)
Dulaney Valley Memorial
Gardens 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Bunai 2 ☐ Cremetion 3 ☐ Removel from Stete August 4 ☐ Donation 5 ☐ Other (Specify) 24, 1999 Timonium, MD 22. Nama and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Pert1. Enter the disease, or complications flef caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only one causa on each line. Approximate interval Batween Onsef end Death **Physician** COMA UNKNOWN /Medicai Immediate Causa (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, laading to immedieta ceuse. Entar Underlying Cause (Diseesa or Injury that Initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as e consequenca of) 98 ettending for use es P.0. Part if. Other significent conditions contributing to death but not resulting in the undarlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown DISLOCATION LEFT HIP Records, þ 24b. Ware eutopsy findings aveileble prior to completion of ceuse of death? Completed 24a. Wes en eutopsy peeu SEIZURE pege 2 s certificate 1 ☐ Yes 2 No Division of Vital al or Attending Physician: To setter death.
I Director: After this certificated in by the funeral director, po Be 25. Wes cesa rafarrad to medicel axaminer? 26. Placa of Deeth (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Othar (Specify) inpatiant 2 ER/Outpetient 3 DOA Certification: To 27. Mepner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

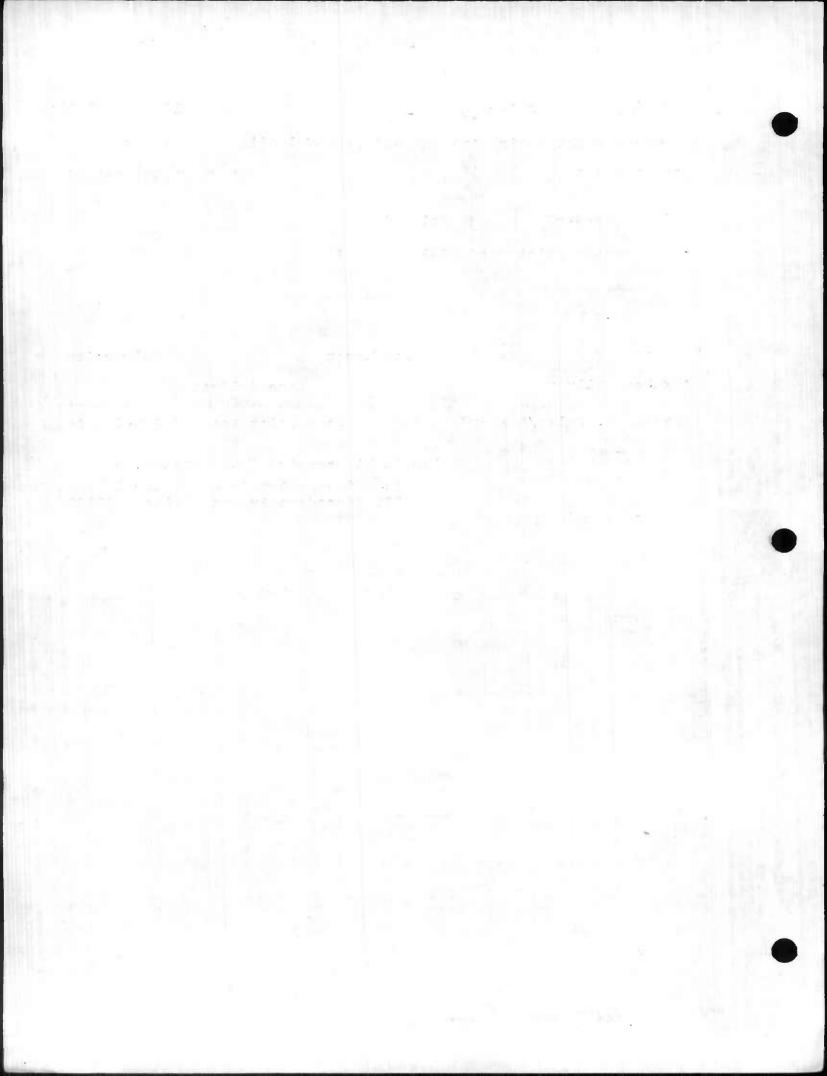
Medical Examiner: On the best of examinetion end/or invastigation, in my opinion, deeth occurred et the time, dete end place, end due to the causa(s) end menner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 6954 30. Wime end eddrass of person who complated cause of daeth (Item 23a) (Type, Print) PEMY CHHIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Deta filed (Month, Dey, Year) 32. Registrer's Signetura State Sparks Registrar



State of Maryland / Department of Health and Mental Hygiene

	1. Decedents Name (First Middle)	and and		tificate of		R	eg. No.	9 261	80
Physician	Decedent's Nama (First, Middle, L	#5t/				2. Date of Dear Month	th Day	Year 3. Tima	or Death
/Medical	Sonia	Osler	_			08	16	99 7:20	pm
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Funeral		Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birthplaca (Stata Country)	or Foraign
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72 hours after death with the Maryland natural, or thems 23e or 28e-f show dical Examiner must be notified at steed by Funeral Director.		oint Road #	603		044				
r heme 23s older must Funeral	11. Marital Status	12. Was Decedent Evar i	n U,S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S	pecify Yes or No-			
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Physician/M	Part II. Other significant conditions	contributing to death but not	rasulting in tha ur	nderlying cause g	iven in Part I.	23b. Did to	obacco usa co	ntributa to the cause	of death?
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edical C	(Check only 2 Medical Exp	hysician: To the best of my	knowledga, death	occurred at the trastigation, in my	ima, data and place	, and due to tha c	ause(s) and ma	annar as stated.	e(s)
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The law requires that the death certificate be executed

Box 68760,

Records, P.O.

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Division

or Attending Physician:

Hospital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 10A-F PER MED G775 9-15 Certificate of Death CEO 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 20 1999 AUGUST 0021 ANNIEUE 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RANDALLSTOWN APT#2 9911 CERVINE LANE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 10 M 20 F Min 438.19.6226 Months Days Hours 38 Yrs. 11-23-100 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits BALTIMORE TE THE 2 NO BALTIMORE MD RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9911 CERVINE LANE APT#2 21133 21225 USA 12. Was Decedent Eyer in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Giva
Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE TEMP. 12 TH GRADE NIA ASSISTANT 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be PRICE ELAINE HOLLAND 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any Injury or other tree ance. 20b. Place of Disposition (Name of cemetery, cremetory or other place) BALTO. YRICE SILAS HATHER MD. 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL GARDONS 8/27/99 ANNAPOLIS, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO . NATL' PIKE, BALTO. mo. 23a. Part1. Enter the desurse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hour farmer. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SUBARACHNOID HEMORRHAGE Examiner Due to (or as e consequence of): Physician/Medical Examiner RUPTURED BERRY ANEURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 12 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 KResidence 6 Other (Specify) Certification: To 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and jiffe of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20,1999 AUGUST

State Registrar

Chute, ma 32. Registrar's Signature

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

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O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #5 PER FH G775 9/13/99 AH State of Maryla AMEND ITEM: #23 PART I PER MEO G774 8-24-99 WR. Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9, 1999 4c. County of Death 10:34pm JOHN August /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins 6. Sex 7. Age (In yrs. last birthday) BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) JUHNS 5. Social Security Number 80 If Under 1 Year Birthplace (Stata or Foreign Country) **Funeral** XXM 20F Months Days 232-82-8220 47 Director 09-24-51 NY **Usual Residence of Decedent** with the Maryland 10a. Slele 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahom must be notified at MD NA Baltimore 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 2111 Barclay Street 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detas: Hems Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 XNever Married 2 ☐ Merried 21215-0020 6 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) other Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) h and Mental H McClelland William Carper 19b. Meiling Address (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 21234 19e. Informant's Neme/Relationship (Type, Print) Department of Health a important: if Item 27 is any injury or other tra-1139 Pelham Wood Road Baltimore, Maryland Valeria White Baltimore, 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donelion 5 ☐ Other (Specify) Dulaney Valley Cem. 08-14-99 Timonium, MD 21. Signature of Funeral Service Licensea 22. Neme and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the delith. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Intervel Betw Onset and Deeth MASSIVE PULMONARY HEMORRHAGE **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner METASTATICO SQUAMODS CELLO CANCER YEARS Examiner hour Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last T4 NZC MT OROPHARYNY SOUAMOUS CANCER and 2 YEARS Box 68760. physician A Static Se Physician/Medical the MI OROPHARYNX Squamous Cell CAMER! 186 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 No director. Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) funerai 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending investigation ours after dean 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

Medical

29a. Certifier (Check only one) 29b. Signature and title of ce

31. Dete filed (Month, Day, Year) 32. Registrer's Signature

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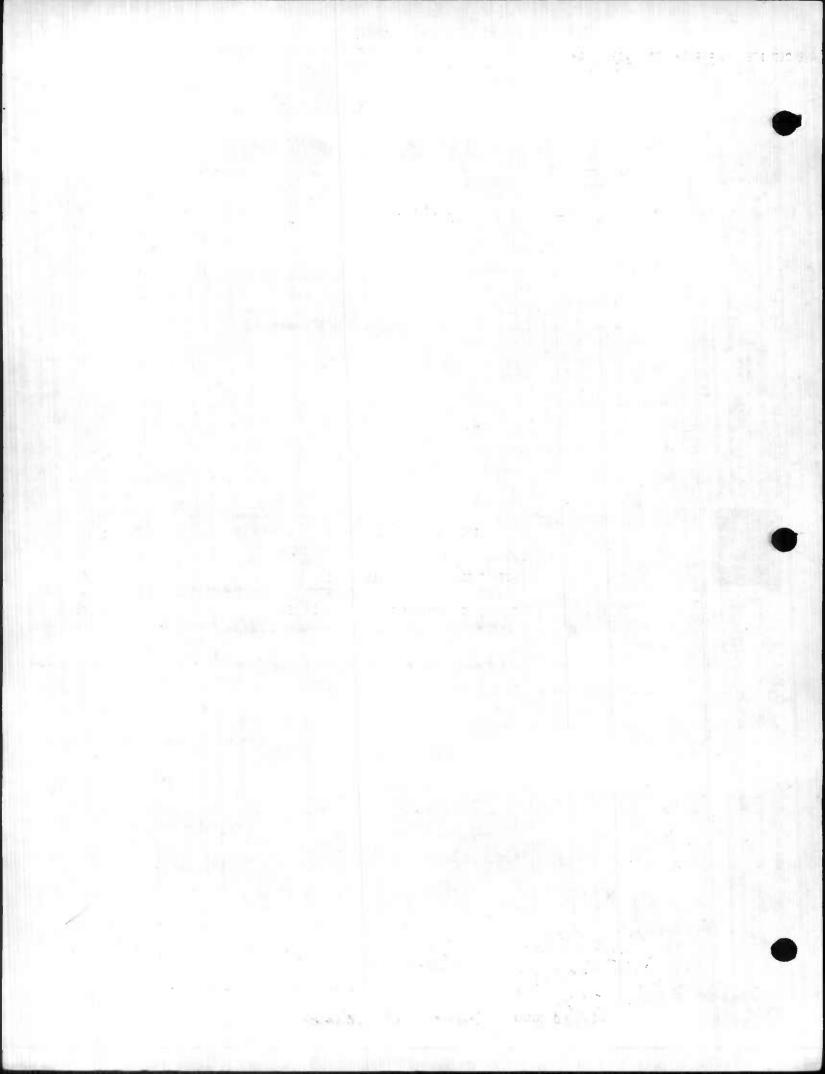
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

olego cause of death (Hern 23a) (Type, Print) Johns Hops bins Hospital

29c. License number

GOO WOLFE Street

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 8:45 AM /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALLSTON If Under 24 Hrs. | 8 Social Security Number 8. Sex. 1 M M 2□ F If Under 1 Year Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Funeral Days Hours Months 330-42-9338 Director MAY 20, 1954 ILLINOIS Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director FALLSTON 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6 items 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Bleck, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No 72 hours after 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baitimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify. py 3 Widowed 4 Divorced Yaar or Dates: ARMY WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Nam 27 is marked other than "na any Injury or other traumatic avance pages. Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY POLICE HELICOPTOIZ PILOT 17 Fethar's Name (First Middle Last) 18 Mother's Name (First, Middle, Maiden Surname) Be EUZABETH ANDREW PETERS 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) M. JEDEGEN C. PETERS SPUUSE FALLSTON , MD. 21047 2902 SEDGEFIELD CT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removal from State AVG. 28, 4 ☐ Donation 5 ☐ Other (Specify) DULANET VALLET MEM. GONS! 1999 TIMONIUM, 22. Name and Address of Facility EVANS FUNDEAR CHAPER - BER AIR 21. Signature of Furtheral Sarvice Licenses 2de-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart tailure. List only one cause on each line. 21050 Approximate Intervel Between Onset and Death **Physician** /Medical fmmediata Causa (Final disaase or condition resulting in death) **Examiner** Examiner melanora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician Box 68760 Physician/Medical the Due to (or as a consequence of P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Wera autopsy tindings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director, 25. Was casa retarred to medical examiner? 1 ☐ Yes 2 ☑ No 80 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide to Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. — Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 295. Signature and title of certifier

DHMH 16 Rev 6/95

who completed cause of death (Item 23a) (Type, Print),

62. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

may by made of the

State of Maryland / Department of Health and Mental Hygiene

Thomas J. Preziosi Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death **Physician** James August 14, 1999 7:37 P.M. nomas PREZIOSI /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** University of Maryland, Shock Trauma Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours 12M 2□F Yrs. 15-34-581 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Directo Md or 28s-t 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3026 21234 Funeral Was Decedent Ever in U,S. Amped Forces? 1 Syas 2 □ No If Yas, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian Black, White, atc. 11. Marital Status hours after 1 Never Married 2 Married ò altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 72 Johns Hopkyus be filed within I Hypiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be Mental REGERICK PRIZIOS 2 MIKIRIKI Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Name of cemetary, crematory or other place) Health a 20a. Mathod of Disposition Data 20c. Location - City or Town, State Department of I Aug. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Signature of Puneral S 22. Nama and Address of Fecility ervice Licens Evans FUNERO, 23a. Part N-Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** The day of stores and one Immediate Cause (Finel disease or condition resulting in death) /Medical Multiple Injuries with Complications **Examiner** Due to (or as a consaquance of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tra of Vital Records, P.O. Box 68760, the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 XUnknown 1 Yss 2 No þ 2 24b. Wera autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? Approval 1 Yas 2 2 No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; After this certification is the funeral director; the funeral director is the funeral director; the funeral director director directors and directors directo 25. Was case rafarred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) XXVas 2□ No Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Subject was a car which struck 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of Division 1 Naturai 5 Pending invastigation Injury passenger in a car whi a tree and overturned. 1 Yas 2 No 07-16-1999 11:10 AM 2 Accidant 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Manor Rd. nr. Glen 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Street Arm Rd., Glen Arm, Maryland. 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the causa(s) Medicai 29a. Certifian manner stated. 29b. Signature and title of cert 29c. License number 29d. Data signed (Month, Day, Year) D27163 August 18, 1999 pleted cause of death (Item 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year) AUG 2 4 1999

32. Registrar's Signatura

parke

M. Neal Reynolds, R. Adams Cowley Shock Trauma Ctr, 22 S. Greene St., Balto., MD

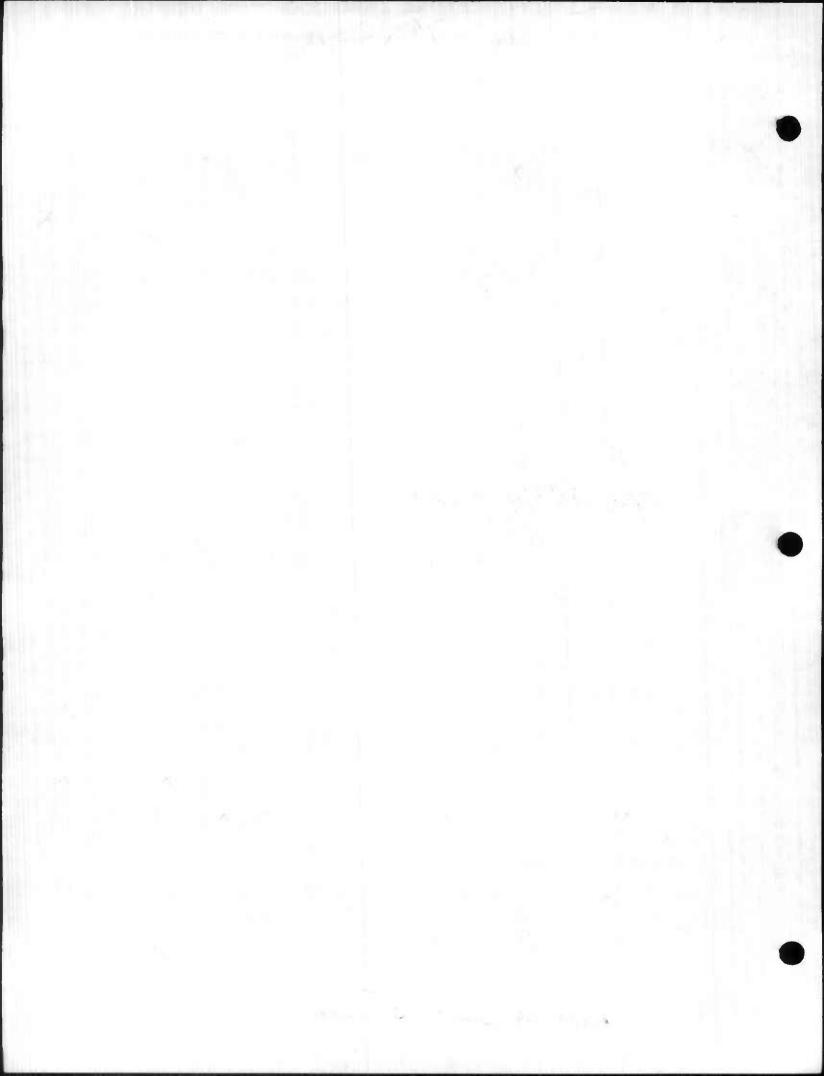
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AMEND #10b-10F PER F.H. G774 8-24-99 J.A.
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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00	raff, c	à	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give 12 Year or Dates:			1□Yes 2ឦN	o Specify:			Specify	W	nite
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	artme ortani Injury	-	4 □ Donetion 5 □ Other (Specify 21. Signature of Funeral Service Licen		Gre		int Crem 2. Name end Add		8/13/99	В	altim	ore,	Maryland
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			30. Neme and address of person who o	completed cause of d				, Balti	more, Mai	ryla	nd 21	201	
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State of Maryland / Department of Health and Mental Hygiene

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land	8 m		10a. State 10b. Count	y		10c. C	ity, Tow	or Location					1	0d. Insid	e City Limits
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	27 r tr		Mr. Rick Ben	nett	Person	al Rep		1635	Germa	n Chaper Ro	ad Prince F	rederick, M	laryland	2067	8
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the Hospital	To the Funeral Director: After completely filled in by the funeral	edical (29a. Certifier (Check only one) Certify	ng Ph	ysician: To the best niner: On the basis of and manners	of my kno of examino	owledga etion and	daath occurre for invastigetion	d at tha ti	ma, data and place opinion, deeth occi	e, end due to tha urred et the time,	causa(s) and m dete end plece,	annar as st and dua to	tated.	se(s)
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8			30. Nama and address of person Milles, Gary A. MI	de	completed cause of 60 Ellicott Cer				Ellicott	City, MD 210	043				
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** 14.05 PM GLADYS V. ROWLETTE 1999 AUGUST /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner N/A BALTIMORE UNION MEMORIAL HOSPITAL If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 11-22-22 Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2X F Deys 215-16-9926 76 N.C. Director Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-fahow 1 Yes 2 No Director N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3915 CALLOWAY AVE. APT. 604 21215 USA items 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bieck, White, etc. filed within 72 hours after. Hygiene. ther then "natural", or ite 1 Yes 2 No
If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: BLACK P 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygiens important: If them 27 is marked other that any Injury or other treumatic avend stand -12-DOMESTIC HOUSEWIFE 18 Mother's Name (First Middle Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be FRENCH WILLIAMS HERNE HARTFIELD 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHEILA MORSLEY (GRAND DAUGHTER) 2539 PARK HEIGHTS TERRACE BALTIMORE, MARYLAND 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 DBuriai 2 Cremetion 3 Removal from Stele Druid Ridge 8-23-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses tha Retor 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final 10 days Schaenuc diseese or condition resulting in deeth) Examiner Examiner yema physicien end the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last ue to (or as a consequence of): Box 68760. Hy potension Physician/Medical 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown old CVA þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed page 2 s 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After the Hospital or Attending 1 Neturel 5 Panding 1 TYes 2 No Investigetion hours after death. 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours of To the Funerel I Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner steted. Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Loven Puthmans, MD AUGUST, 17, 1999 AT 2438946 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) PuthunaNA, MD HOSPITAL UNION MEMOIZIAL LOVEEN 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture AUG 2 4 1999 Registrar

cell as DUA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death qq q **Physician** 3:45 PM ROBINSON 8 HOMAS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYUMD HOSPITM If Under 24 Hrs. If Under 1 Year 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 15 M 2□ F 67 217-24-1865 Director M.D Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No 288-7 Baltimore NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 늄 8 Name 234 21201 U.S.A. 124 West Franklin St Apt 1008 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 Yes 20 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ñ filed within Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Maintenance Morgan State College na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Pages 1 and 2 should be nent of Health and Mental is marked 2 Thomas L. robinson 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If Item 27 ter 2801 Allendale Road, Baltimore Md

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Tox Charlena Scribner-Daughter 21216 20c. Location - City or Town, State 20a. Method of Disposition Separtment of ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 8/25/99 Baltimore, md 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility March F/H WEst 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition resulting in death) Examiner Due to (or as a consequence of): AMEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): ARTBRY OROWATEL 68760 Physician/Medical å Due to (or es a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Àq Records, 24b. Wera autopsy findings evailable prior to Completed 24a. Was en autopsy completion of cause of death? 1 ☐ Yes 2 No 1 Tyes 2 No cartificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 書 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Ather Attending 1 Matural 5 Pending investigation 1 Yes 2 □ No death. 2 Accident f or Attend shar deall Director. 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of parson who completed cause of death (Item 23a) (Type, Print) MD BALTO, MO S. GREENES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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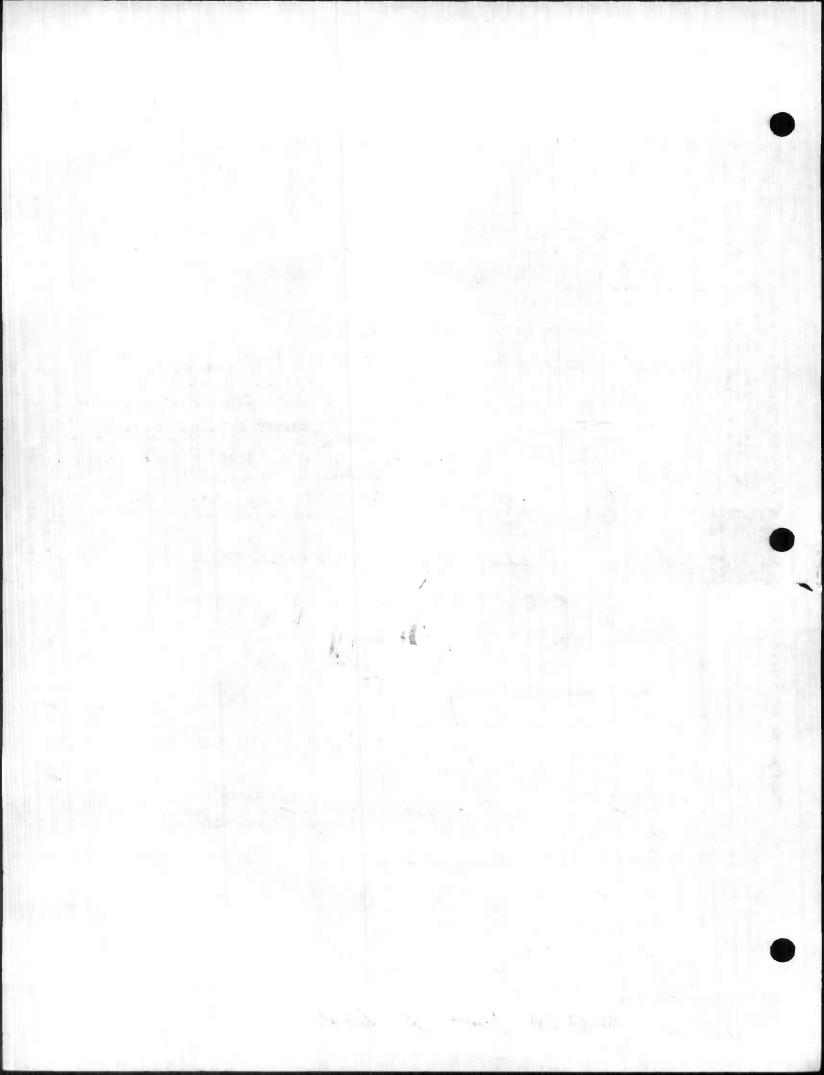
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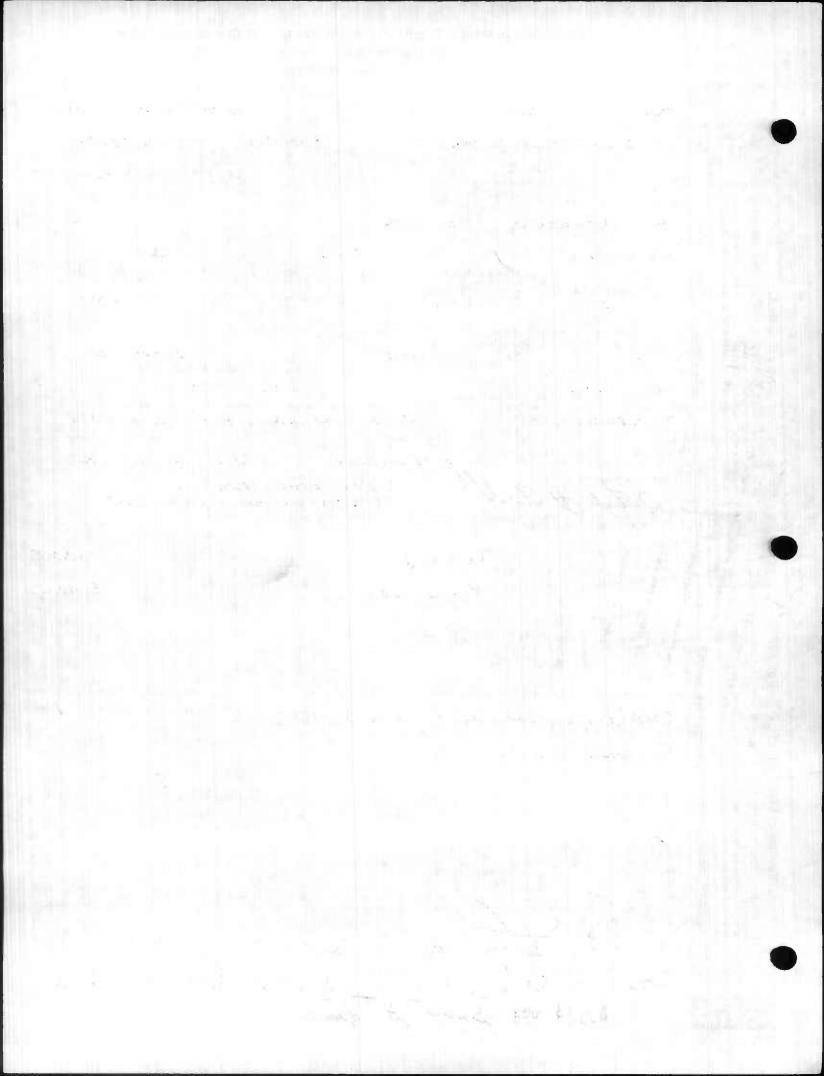
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Examiner	4a Facility Name (If not institution, g	give street and number)			- 1	4b. City, To	wn, or Location		4c. County		
	Anne Arundel Me	edical Center	r			Annap	olis		Anne	Aru	ndel
Funeral	Social Security Number 6.		(In yrs. last birth		r 1 Year			ate of Birth	Vees	9. Birth	place (State or Foreign
Director	039-20-0651 Usuel Residence of Decedent	1QM 2□ F	69 Yr	Months	Days	Hours	Ap	RIL E		Mass	achusetts
Ma =	10a. State 10b. County	1	10c. City, Town	or Location							10d. Inside City Limits
r 28a-f show incillised at	MD Anne Ar	rundel	Annapol								1 ☐ Yes 2 ☐ No
	10e. Street and Number 111 Silopanna			10f. Zip	1403			10	USA	What Cou	ntry?
ter deam ter must ner must	11. Maritel Stetus	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was Dece	dent of H	ispanic Orl	gin? (Specify)	Yes or No-		ce - Ameri	can Indian,
	1 Never Married 2 Married 3 Widowed 4 Divorcad		orean	1 ☐ Yes			, 1 40110 111021	., 0.0.,		y: Wh	
ygiena. Ner than "netural", It, I'm Modical Eq.	15. Decedent's (Specify only highest (Education	16a. D	ecedent's Usu Give kind of wo ife. DO NOT u	ork done	during most	t of working		16b. Kind of B	usiness/In	ndustry
then.	Elementary/Secondary (0-12)	College (1-4or 5+)			50 1011100	u)			Ela-t-		
other t	12 17. Father's Name (First, Middle, La	5+	OWI	ier		10 Mothe	er's Name (Fin	at Middle A	Electr		S
Mental Hyg srked other stic event, To Be C	Ralph Riddle	st)				Luc		arvin	raideir Sumai	ne/	
traum	19a. Informant's Name/Relationship Ralph Riddle -			Meiling Address							p Code) 1403
f Health ftam 27 other tr	20a. Method of Disposition		20b. Place of E	Disposition (Na crematory or	me of	001	De	ate 2	20c. Location	- City or T	own, Slate
0 0	1 ☐ Burial 2 ☑ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		Metro (Cremato	ry		8/		Baltim	nore,	MD
Department Important: Page any Injury o	21. Signature of Paneral Service Lic	and (al Homo			21401	
	23a. Pert1. Enter the diseese, or co shock, or heart failure. List on	omplications that caused th	ne death. Do no							11401	Approximate
hysician	shock, or heart failure. List on	ly one cause on each line								i	Interval Between Onset end Death
/Medical xaminer	Immediate Cause (Final disease or condition resulting in deeth)	. w	rosip	212							5 days
	resulting in deedil)		ue to (or es e co		:						5 days
in a		Pu	leumo	ma						1	5 days
physician and s the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Di	ue to (or as a co	nsequence of)	:						
g physicie as the bu	Cause (Disease or Injury that initiated events resulting in death) Lest	C	ue to (or as a co	nsequenca of):							N. S.
ed by the ettending place as the detached for use as the place and the p		d									
the ched	Part II. Other significant conditions	contributing to death but	not resulting In t	he underlying	cause giv	ven in Part i	i.				to the cause of deat
gned by be detac	CVA (Cerebr	al vasculo	er ac	ciden	(*	1989	?	1 🗆 Y	2 □ No	3 Pro	obably 4 Unkno
In a law requires that the death centilicate be associted take has been signed by the ettending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examir	Suzure D	al rasculo	989					24e. Was e perforr	n autopsy ned?	a c	Vere autopsy findings vailable prior to ompletion of cause f death?
ate has pege 2								1 □ Ye	s 2 No	1	☐ Yes 2☐ No
certificate rector, peg	25. Was case referred to medical					00 81	(D 1) (O)				
s certific director,	examiner?	Hospitel:			Oth	ner .	e of Death (Ch				
5 5 5	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending	28a. Dete of Injury (Month, Day)			28c. Inju	4 LI NU	ursing Home 28d.		ow Injury occu		ify)
2 20 2		tion		М		Yes 2	No				
After fune	2 ☐ Accident investigat		y - At home, farr	n, street, factor	ry, offica		28f. I	Location (St City or Town	reet and Num n, State)	ber or Rui	ral Route Number,
Afte fune	2 Accident investigat 3 Sulcide 6 Could not 4 Homicide	building, etc.	,								
After fune	3 Sulcide 6 Could not determine 29e. Certifier Check only 2 Medical Ex	Physician: To the best of caminer: On the best of caminer:	my knowledge, xaminetion end/	death occurred or investigation	at the tin	me, date an	nd place, and on the occurred at	due to the ce	suse(s) and mate and place,	anner es	stated. to the cause(s)
After fune	3 Sulcide 4 Homicide 29e. Certifier (Check only one) Could not determine 6 Could not determine	Phyelclan: To the best of	my knowledge, xaminetion end/	or investigation	n, In my c	opinion, dea	nd place, and cath occurred at	the time, de	ate and place,	, and due	to the cause(s)
Afte fune	3 Sulcide 6 Could not determine 29e. Certifier Check only 2 Medical Ex	Physician: To the best of caminer: On the best of caminer:	my knowledge, xaminetion end/	or investigation	n, In my c	me, date an opinion, des	nd place, and cath occurred at	the time, de	euse(s) and mate and place,	, and due	to the cause(s)
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eeth. or: Afte the fune catior	3 Sulcide 4 Homicide 29e. Certifier (Check only one) 29b. Signature end title of certifier	building, etc. Phyeician: To the best of caminer: On the best of early marker state	my knowledge, xaminetion end/	or investigation	n, In my c	opinion, dea	and place, and on the occurred at the occurred	the time, de	ate and place,	, and due	to the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 7:30 PM Robert AUGUST 21 1999 Δ. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Rosedale FRANKLIN WOODS BALTIMORE HOME NOTSING Hunder 24 Hrs. 8. Date of Birth (Month, Dey, Yaar) 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax Days 10 M 2□ F Months 2 SEPT 30,1916 217-01-7445 MD Usual Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No PARKVILLE Director MD BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U. S.A AUE 21234 HILLCREST 2607 Funerai 12. Was Decedant Evar in U,S. Armad Forces? 1 Yas 2 No 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Biack, Whita, etc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 ff ff Yas, Giva Year or Dates: 1 Yas 2 No Specify: WHITE þ 3 D Wildowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) 12+h SELF NIA IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) RAGAN ANNA ZAHN To ALLEN 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) JEVA CLOOWING SEX Belair MD BETTY ANNE DOLE 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlei 2 □ Cramation 3 □ Ramoval from Stata 8/25/99 BALTO. MD MORELAND CEMETERY 4 □ Donation 5 □ Othar (Specify) HARTLEY MINER FURERS HOME CHTD. 22. Nama and Address of Facility 21. Signatura of Funaral Sarvice Licensea 23a. Part 1. Enter the disease, a complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. Approximate tntarvel Between Onsat and Death fmmediate Causa (Final Recurrent Ling Cancer 14 mo. disaasa or condition rasulting in daath) Dua to (or as a consequence of) Examiner Sequentially list conditions, if eny, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 1 10 108 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy findings availabla prior to complation of causa of daath? 24a. Was an eutopsy Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical examinar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 No 10 1 Inpatiant 2 ER/Outpatiant 3 DOA 28a. Data of fnjury (Month, Dey Year) 28d. Describe how injury occurred 27. Mannager Death 28b. Tima of 28c. fnjury et Work? Certification: 5 Pending invastigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Records, P.O.

Funeral

Director

Itam 27 is marked other than "natural", or Itams 23e or 28e-f show other treumetic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Meniel Hygiene. Important: If item 27 is merked other than "natural", or items 23e any Injury or other treumetic event, the Medical Examiner mast once.

Physician /Medical

Examiner

attending physician end for use as the bunal-transit

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65 980

Baltimore, Maryland 21215-0020

the Maryland

certificata be axecuted

page 2 certificate Division of Vital After this funeral or Attending efter death. 24 hours e Hospital To the I within 2

State

Medicai

3 ☐ Suicide

(Check only one)

29b. Signatura and titla of certifier

29a. Certifier

m.D.

28e. Placa of injury - At homa, farm, streat, factory, office building, atc. (Specify)

29c. Licansa number D 45390

1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the tima, data and placa, and dua to the cause(s) and mannar as steted.

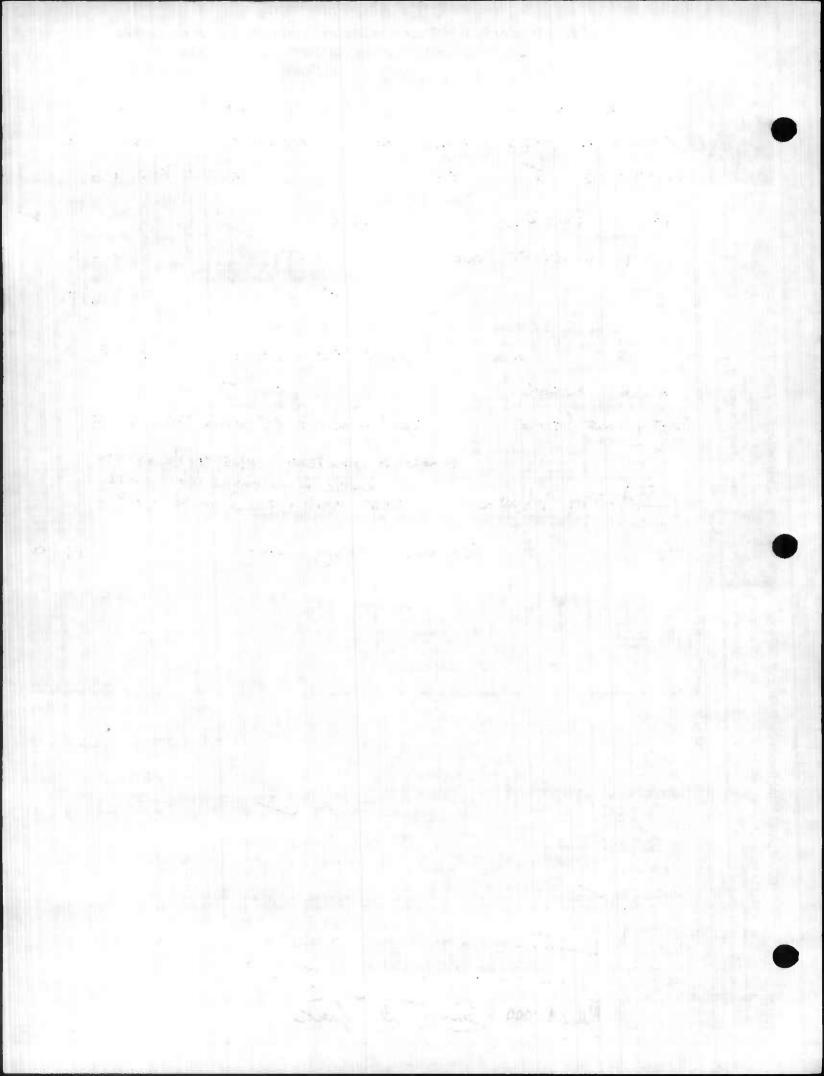
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29d. Dete signed (Month, Day, Year) 8/23/99

(COMD WIN OVER 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) 6830 HOSPITAL DR # 206, GALTIMORE. MD 21237

31. Data filed (Month, Day, Year) AUG 2 4 32. Registian's Signatura

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death Month **Physician** 0 /Medical 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Birthplaca (State or Foreign Country) Hours 01 5608 Ennsy Lumn Usuel Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits BATHINGE 1 Ves 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21218 0513 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yas 20 No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritel Status 14. Race - American Indien. Bleck, Whita, atc. 2 Merriad 1 ☐ Navar Married 1 ☐ Yas 2 No Specify: PV Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) GRINDER YEAR 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumerne) Be HAME IREME 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Jown, Stata, Zip Code) SLIFER 1BroTHEN DURLYN DRIVE Ethel HA 20a. Mathod of Disposition 20b. Place of Disposition (Nama of / Data 20c. Location - City or Town, Stete cematary, cramatory or other place) 1 ☐ Buriel 2 Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) lount Carretery 21. Signeture of Funaral Service Licensi 22. Nama end Address of Facility 5240 KCI STENS HOUN RIAD 23a. Part1. Enum the crease, or complications thet caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heer I mure. List only one cause on each line. Approximate intarval Between Onset and Death Congestine heart immediate Ceusa (Final disaasa or condition rasulting in death) Dua to (or es a consequançe of): Examiner dio m 06 Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseesa or Injury that initiated evants resulting in daath) Last Dua to (or as a consequance of) Pert ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Netural 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accidant

signed by the attending physician and d be detached for use as the buriel-transit Division of Vitai Records, P.O. Box 68760, requires thet the death certificate be certificate hes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heath and Mental Hypiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Mandias Examinan must be notified as

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

death with the Maryland

Physician/Medical Completed by Be 70 Certification:

3 Sulcida 4 ☐ Homicide Medical 29a. Cartifian (Check only one)

29b. Signeture-and titla of certifian

6 Could not be datarmined

29c. License number

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year)

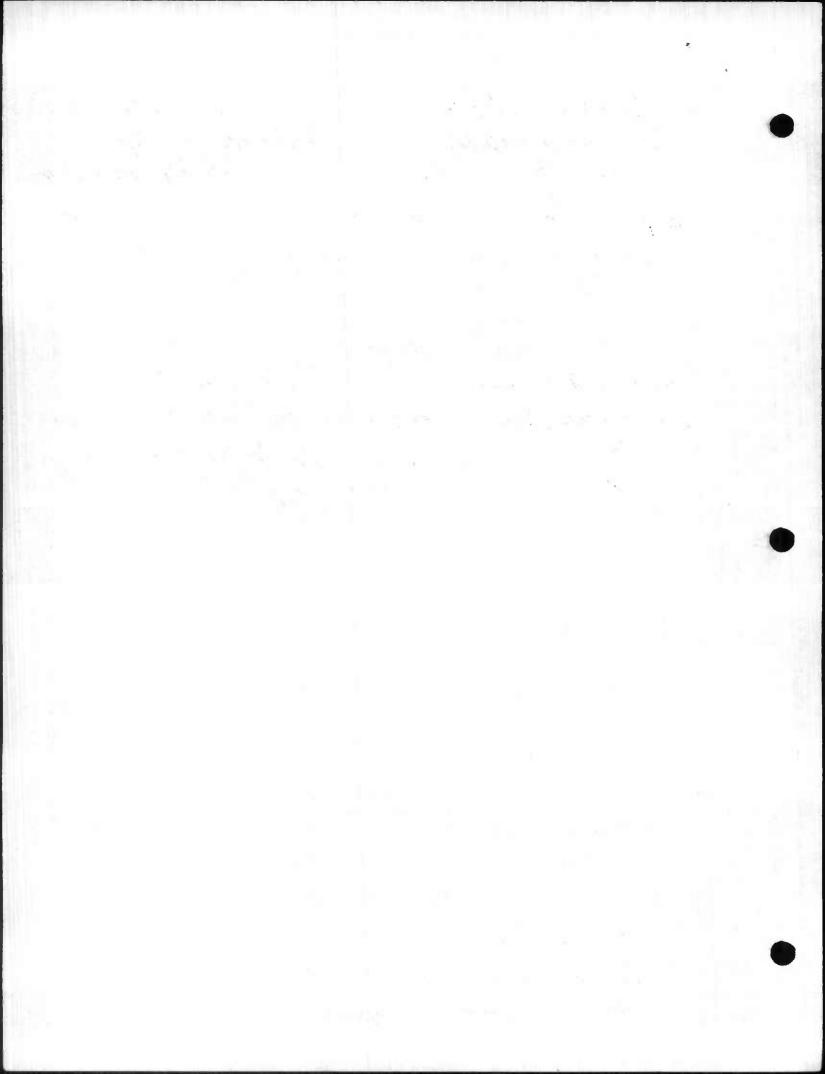
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

pleted causa of deeth (Item 23a) (Type, Print) MOUNT Royal Aur, Name and address of person who completed causa of deet DALSHAN_S.SALU/AMJ 1600 W. 31. Dete filed (Month Day, Year) AUG 2 4 1999

State Registrar

32. Registrar's Signature

28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify)



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	R	eg. No. 9 9	26593
Dh	ysician	1. Decedent's Name (First, Middle, Last)				2. Date of Deal Month		3. Tima of Death
	Medical		SHETRONE,	SR.		AUGUST	22 1999	2:25 PM.
Ex	aminer	4a Facility Name (If not institution, giva s			4b. City, Town, or Loc		4c. County of	
27.7		MARINER HEALTH C 5. Social Security Number 6. Sex			GLEN BURNI			RUNDEL CO.
Fun Dire	eral ctor		M 2□F 87	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day) Aug. 11	1912	Birthplece (State or Foreign Country) York, Penna.
rytand	9 .	10a. Stete 10b. County		wn or Location				10d. fnsida City Limits
Se Ma	be notified at Director	Md. n/a	Balt	cimore				1√ Yes 2□No
Eh with It	24 0	1100 Church Stre	et	10f. Zip Code	2122		0g. Citizen of Wh USA	at Country?
Maryland 21215-0020 d2 should be flad within 72 hours after deal it and Mental Hygieria. 7 is marked other than "natural", or leans	Examiner must	11. Marital Status 1 1 Never Married 2 Merried 3 Awidowed 4 Divorced	2. Was Decedant Ever in U,S. Armed Forces? 1 Tyes 2 No If yes, Give? Yeer or Detes:	13. Wes Decedent of I If Yes, specify Cub		cify Yes or No- Rican, atc.)	Bleck,	American Indian, White, etc. White
12 Ta	etec	15. Decedent's Educ (Specify only highast grada	ation 16. completed)	a. Decedent's Usual Occu (Give kind of work done	during most of working	g	16b. Kind of Bust	ness/Industry
12	A, the Medical	Elementary/Secondery (0-12)	Cottege (1-4or 5+)	life. DO NOT use retire	od)	1000	D.C.	D
d 2		17. Father's Nema (First, Middla, Last)	0	Guard	18. Mother's Neme	(First, Middle, I	B.G. & Meiden Sumame)	
la be	o Be	John Shetrone, Sr				ie Stri		
ary shou	T T	19e. Informant's Neme/Relationship (Typ.		9b. Meiling Address (Street				teta, Zip Coda)
- 5 9 %	ž ž	Richard E. Shetron	ne, Jr. (Son)	14007 Old Ha	nover Road	, Reist	erstown,	Md. 21136
Baltimore emit. Pages 1.1 Separtment of He reportant. If Nem	ury or oth	20a. Method of Disposition 1 ↑ Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emovel from Stata 20b. Plece cement Holy	of Disposition (Name of tery, cremetory or other play Cross Cemet	ice)	Dete	20c. Location - Ci	
Balt Depart	any inj	21. Signature of Funeral Service License	^e Kevin E. Ecker	Inccurry-	esa of Facility Polyniak Fi atapsco Ave	uneral	Home P.A	Md. 21225
		23a. Part1. Enter the diseesa, or complice shock, or heart teilure. List only on	ations that caused the deeth. Do	not enter the mode of dyi	ing, such as cardiac or	respiratory arr	est,	Approximate Interval Between
Physic								Onset and Deeth
/Med Exam		Immediata Ceusa (Final disease or condition resulting in death)	Prostat	e lanc	er			Syears
		1050tting in coating	Due to (or as a	e consequence of):				
68760, ificate be asscuted physician and	s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of):				
68760, ficate be ax	burie Cal E	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events	Pilaton					i
0 = 2		resulting in death) Lest	Due to (or as e	o consequence of):				
death cert	and and	d.						1
O. E.	etached for use Physician/M	Pert II. Other eignificant conditions cont	ributing to death but not resulting	in the underlying cause gi	ven in Pert I.	23b. Did to	bacco use contr	ibute to the cause of death?
cords, P.O. v requires that the de been signed by the t	detact y Phy					1 U Y	es 2 No 3	Probably 4 Unknown
Records, ne law requires to has been signe	page 2 should be d					24a. Was e		24b. Were autopsy tindings
law rec	Short					perton	med?	available prior to completion of cause of death?
I Rec	age om					1 🗆 Y	es 2500	1 ☐ Yes 2 DNo
Vital	Be C	25. Wes case reterred to medical			26. Place of Deeth	(Check only on	10)	
of Vita Physician: this certific	To E	axaminer?	ospitel: 1 Inpatient 2 ER/C	Outpatient 3 DOA Ot	her: 4 Nursing Hor	na 5□ Reside	ence 6 Othar	(Specify)
0 4 to	neral	27. Manner of Death 1 DNeture 5 □ Pending	28a. Dete of Injury (Month, Day Year) 28b.	. Time of 28c. Inju	ry at 2	8d. Describe h	ow injury occurred	
Vision Attending or death.	the fu	2 Accident investigation			Yes 2 No			
Division of or Attending Phys after death. Director: After this	led in by the funera Certification:	3 ☐ Sulcida 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	ferm, atreet, fectory, office	2	8f. Location (Si City or Town		or Rural Route Number,
Hospital 24 hours a Funeral		29a, Certifier 1 Certifying Physi	Islam. To the boot of our bounded	and a share a second at the st	and data and alone a	and office the three of	(a) and man	
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha	pletely fill edical		clan: To the best of my knowledger: On the basis of examination a and menner steted.	and/or investigation, in my	opinion, deeth occurre	d at the time, d	ate and place, an	d due to the cause(s)
To the To the	Me	29b. Signature and title of certifier	2	29c. Licen	se number	2	9d. Date signed (Month, Dey, Year)
	~	1 dont	n	05	0725	0	8/23/	199
		30. Name and address of person who con	npleted cause of death (Item 23a)	(Type, Print)	ttal R	V. Serry	rno Pa	99 LL MD 21146
10	State	31. Dete tiled (Month, Dey, Year) AUG 2 4 1999	32. Registrer'a Signature	Lumps	SVIOLENCE			
Re	gistrar	100 E = 1999	The D.	sparker	_			

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Secretary and the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death GERTRUDE ROSETTA SCHUMAN AUGUST 20 12.10 am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 3001 SOUTH HANOVER BALTIMORE CITY STREET n/a HARBOR HOSPITAL CENTER 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day Aug. 10 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign Country) Maryland 6. Sex Y 1909 Months Days Hours 1 ☐ M 2 € F 90 Yrs 217-34-9302 Usual Residence of Decedant 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida Cltv Limits 1X Yas 2 No Baltimore n/a Md. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 600 Light Street Apt. #210 21230 12. Was Decedant Evar In U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian Black, Whita, atc. 1 Yas 2V No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2√2 No Specify: Specify: white 3 XWidowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa retired) Elementery/Secondary (0-12) Collega (1-4or 5+) Housewife Home Owner 18. Mothar's Nema (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Adams Carrick Elsie M. Joseph H. 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 163 Kenwood Road Rivera Beach, Md. 21122 William E. Schuman (Son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 NBurlal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 8/23/99 Brooklyn Park, Md. Cedar Hill Cemetery 21. Signature of Funaral Salvice Licanses 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Epter tha diseasa, or complications that ceused tha daath. Do not entar tha moda of dylng, such as cerdiec or respiretory arrest,

App. shock, or haart failure. List only one ceuse on each line. Approximata Interval Batwaan Onsat and Daath Immediata Causa (Final FIBRILLATION . ATRIAL disaase or condition rasulting in daath) TEN DAYS Dua to (or as a consaquanca of) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part tt, Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I 1 Yes 2 No 3 Probably 4 Unknown RENAL CELL CARCINOMA OF RIGHT KIDNEY 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? WITH LUNG METASTASES 1 Yas 2 No 1 Yes 2 No 25. Wes cesa refarred to medicel axaminar? 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examine

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Physician/Medical

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Completed

Certification: To

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Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

Directo

Funeral

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Completed

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mentel Hygiena. Important: If Hem 27 is marked other than any follury or other traumed.

physician end the burial-transit The law requires that the death certificate be asscuted 80 980 for ed by the e signed t s certificate has b

P.O. Box 68760. Division of Vital Records. or Attending Physician: funeral director. this After deeth. after deeth Director: filled in 24 hours a Hospital within 24 ho To the Fune completely fi

> State Registrar

KAVITA BADAL SANGHVI 31. Date filed (Month, Dey, Yeer)

K.B. Sanghin MD.

5 Pending

6 Could not be datarmined

Invastigation

309-F LIMESTONE VALLEY DRIVE, COCKEYSVILLE MD-21030 32. Registrar's Signetura south

LINTERN

1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of

28c. Injury at Work?

1 Certifying Physician: To tha best of my knowladga, daeth occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa numbar

1 ☐ Yas 2 ☐ No

AS2441614A48

28d. Dascribe how Injury occurred

AUGUST

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

28a. Data of Injury (Month, Day Year)

1 Yas 2 No

27. Mannar of Daath

1 Natural

2 Accidant

3 Sulcida

29a. Cartiflar

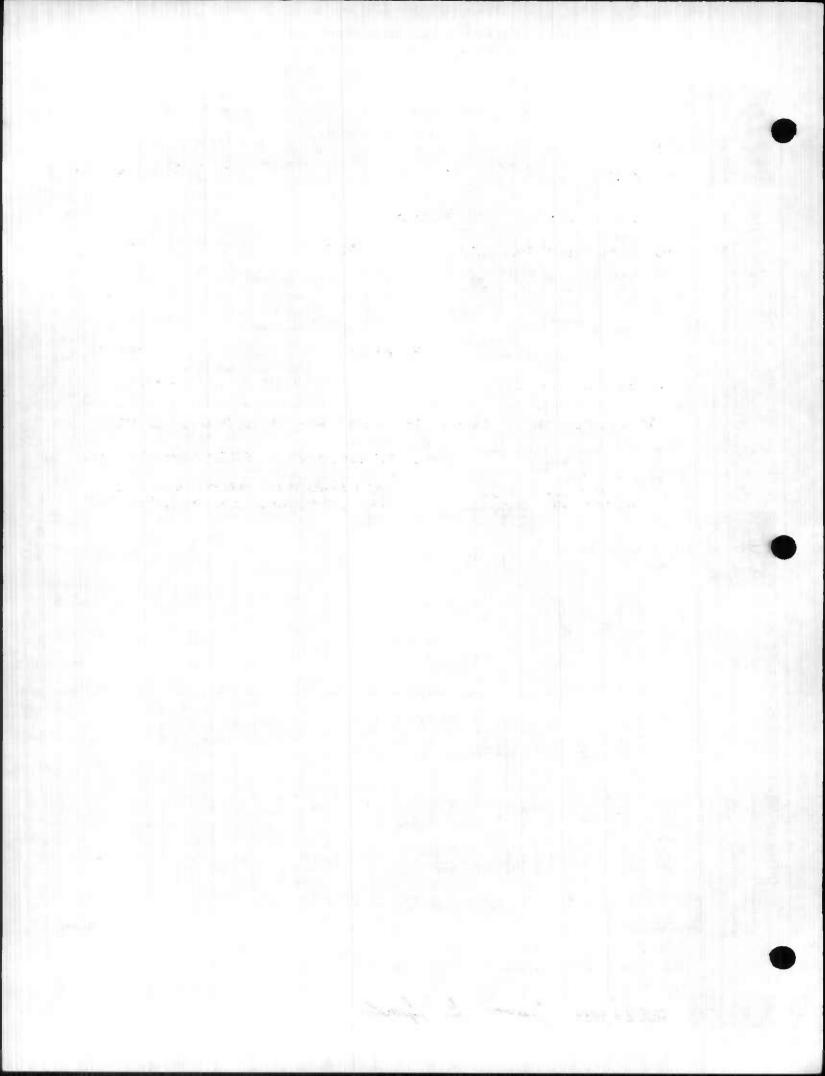
4 ☐ Homlcida

(Check only one)

29b. Signatura and titla of certifian

AUG 2 4 1999 **DHMH 16 Rev 6/95**

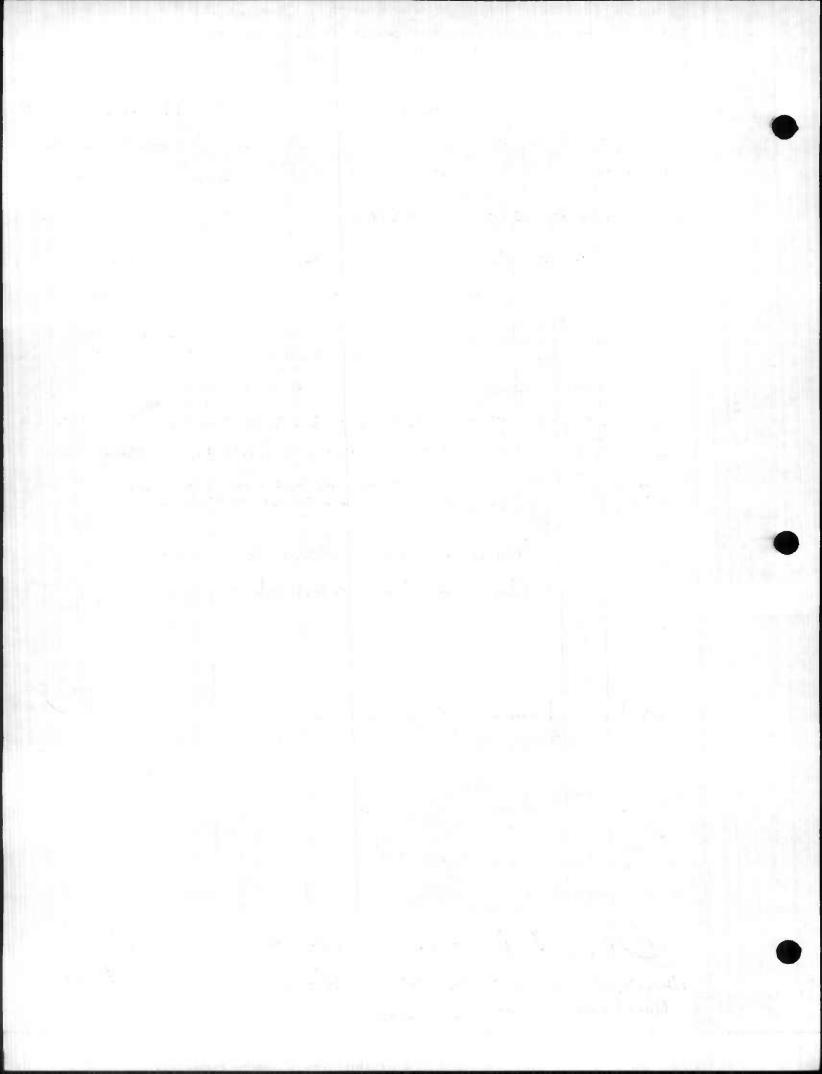
30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No.	2	5595
	Physici /Medi		Decedent's Name (First, Middle, Lest) Harry W. Schuman	2. Date of De Month	Day	Year 1999	3. Tim f th 7:25 M
	Examir Funeral Director		4a. Fecility Name (If not institution, give street end number) North Arundel Hospital 5. Social Security Number 212-01-3755 6. Sex 1 Mm 2 F 88 Yrs. 4b. City, Town, or U Glen Bu 7. Age (In yrs. last birthdey) Months Days Hours Min.	ernie 8. Dete of Bir (Month, De	Anne	Arun 9. Birthp Coun	del Co.
	σ	or.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Co. Pasadena	April	2,1911	Mary.	Land Od. Inside City Limits 1 □ Yes 2 No
	or 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhat Coun	
020	d 2 should be filed within 72 hours efter death with the Manyland th and Mental Hygiena. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exporter must be notified.	by Funeral	8140 Forest Glen Drive 21122 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorcad 212. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify:	pecify Yes or No Rican, etc.)		k, White,	an Indian,
Maryland 21215-0020	filed within 72 ho Hygiene. ther then "netur: ort, the Medical.	Completed	15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) 12 16a. Dacedant's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Paddy Wagon Driver 17. Fether's Name (First, Middle, Last) 18. Mothar's Name		Baltimo Police	re C Dept	ity
ylan	should be ind Mental i marked or umatic eve	To Be	George A. Schuman Elizabe	th Bish	op		
altimore, Mar	of Heal		19a. Informent's Name/Relationship (Type, Print) Judith A. Bortner Niece 20a. Method of Disposition 15 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	e Pasade	ena, Mary	land	21122
Balti	permit. Pege Department of important: If any injury or		21. Signature of Funeral Servica Licansee Chustina Atliton 22. Name and Address of Facility McCully-Polyniak F 3204 Mountain Road	Pasade	na, Maryl		
	Physician /Medicai Examiner		23a. Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failura. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of):				Approximate Interval Between Onset and Death
68760,	tificeta be executed ng physician and as the buriel-trensit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Last b. Chronz cthraft for illation at the cause of the cause (Disaase or Injury that initiated events resulting in death) Last b. Chronz cthraft for illation cause of the cause	~			
Box	death certifi a attending I d for use as	Physician/N	d. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did	tohango usa gor	atribute to	the cause of death?
, P.O.	v requires that the de been signed by the s should be detached	by Phys	Brady in ythmia and Jacemaller		Yes 2 No	3 Prol	
Records,	2 5 0	Completed b	0		an autopsy ormed?	ava	ere eutopsy findings ailable prior to mpletion of cause deeth?
Vital R	E as a	Be Con	25. Was case referred to medical 26. Place of Dea	th (Check only)		10	Yes 2GNo
	hys light	2	axaminar? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing H 27. Mannar of Death 28a. Data of Injury. 28b. Tima of 28c. Injury at	ome 5 Resi	danca 6 □Oth		1)
Division of	To the Hospital or Attending P within 24 hours effect deeth. To the Funeral Director: After the completely filled in by the funeral prices.	Certification:	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida (Month, Day Year) Injury Work? 1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (City or To	Street end Numb wn, Stete)	er or Rure	l Route Number,
	thin 24 hours thin 24 hours the Funeral mpletely fille	Medical C	29a. Cartifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the date of the control of the contro	and due to the rred at the tima,	date and placa,	and due to	the causa(s)
)	T will		290. Signatura and actions of person who completed cause of death (Item 23a) (Type, Print) Christopher deBon; 4 MB 3708 Mountain Rel		29d. Date signed		
1	Sta	te	Christopher deBorj 4 MD 3708 Mountain Rel. 31. Date filed (Month, Day, Year) Se. Registrar's Signature	, Chesa	elena,	Md.	21/22

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Lest) 2. Data of Death Month Yaar WILLIAM ANDREW STEPCICH AUGUST 23,1999 Ø2:45 PM 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give straat and number) 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Months Days Hours 1 X M 2 □ F 216-05-7205 93 Oct.22, 1905 Maryland Usual Rasidanca of Decadant 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1X Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5507 Plainfield Avenue 21206 U. S. A. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Marriad 1 ☐ Yas 2 🗓 No Specify: Specify: White 3 X Widowed 4 ☐ Divorcad 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Dacadant's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Baltimore City Elamantary/Secondary (0-12) Collega (1-4or 5+) 8th Grade Police Officer Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Anton Stepcich Mary Zitnik 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3 Stonehurst Road, Phoenix, Maryland 21131 Joseph A. Stepcich (Son) 20b. Place of Disposition (Neme of cematary, crematory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cramation ☐ F A Pemoval from Stata 8/25/99 Baltimore, Maryland Most Holy Redeemer 21. Sign of Funaral Sarvica L 22. Nama and Addrass of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List up one cause on each line. Approximate Intarval Batw Onsat and Daath Immediata Causa (Final PNEUMONIA 1 WEEK disaasa or condition rasulting in daath) Dua to (or as a consaquance of): HYPONATREMIA 1 MONTH Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated evants rasulting In daath) Last Dua to (or as a consequence of): DEHYDRATION Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of causa of death? 25. Was casa rafarrad to medical 26. Placa of Death (Check only one) 1 Yas No Hospital: 1 Unpatiant 2 ER/Outpatiant 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dey Year) 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartitian

physician and s the bunal-transit P.O. Box 68760, been signed by should be detec Records, certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific To the Hospital of within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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7 is marked other than "natural", or items 23s or 28s-f shov traumetic event, the Medical Experimen must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatin access

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Baltimore, Maryland 21215-0020

the Marylend

State Registrar

31. Data filed (Month, Dey, Year) AUG 2 4 1999

29b. Signatura and titla of cartifiar

32. Ragistrar's Signatura

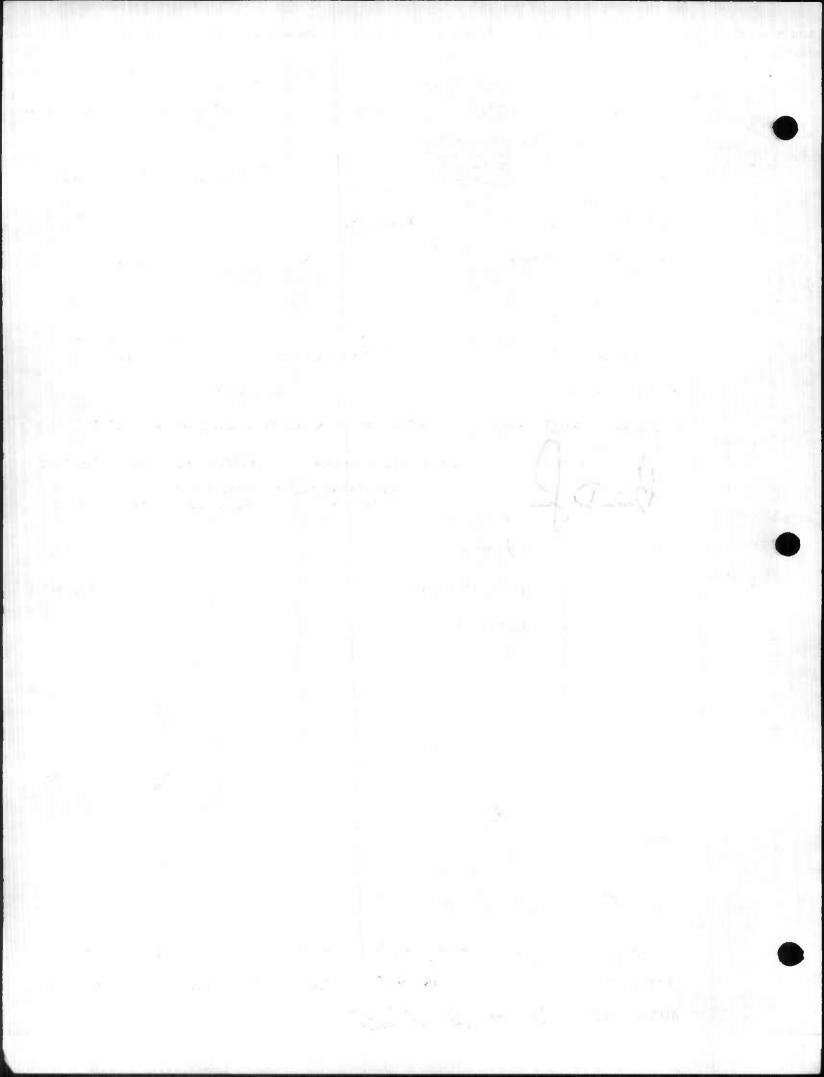
natividad D. de Leon, m. D. D

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

NATIVIDAD D. DE LEON, , M. D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

29c. Licansa number

29d. Data signad (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Year 50 **Physician** MICHIT 20 1499 Otto Adam Schaub /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2□ F Yrs 75 July 24, 1924 Maruland Director 218-14-8963 Usual Residence of Decedent the Marylend 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylen neat of Health and Mental Hygiene.

ent of Health and Mental Hygiene.

int: If term 27 is marked other than "natural", or frems 23a or 28a-f show that it is reading Examine. The mat be notified at any or other traumatic event, the Madical Examine. 1 Yes 2 No Directo Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zin Code 3513 Harford Road 21218 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black. White, etc. 1 X Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Laborer Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Schaub Martha Kimmel 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Audrey Bopp (Sister) 431 W. Maple Road, Lithicum, Maryland 21090 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burlei 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of 4 □ Donation 5 □ Other (Specify) Loudon Park 8/23/99 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** small cell un /Medical Immediete Ceuse (Finei disease or condition resulting In death) Examiner Due to (or as e consequence of): Examiner and Il-transit that the death certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of) for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? been signed by the should be detach 1 Nos 2 No 3 Probably 4 Unknown by The law requires 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? is cartificate has be director, page 2 s ALI No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this cartilica staly filled in by the funeral director, f Be 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Direc-4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and little of 29c. License number mil address of person who combieted cause of death (Item 23a) (Type, Print) 30. Name and

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32. Registrer's Signature

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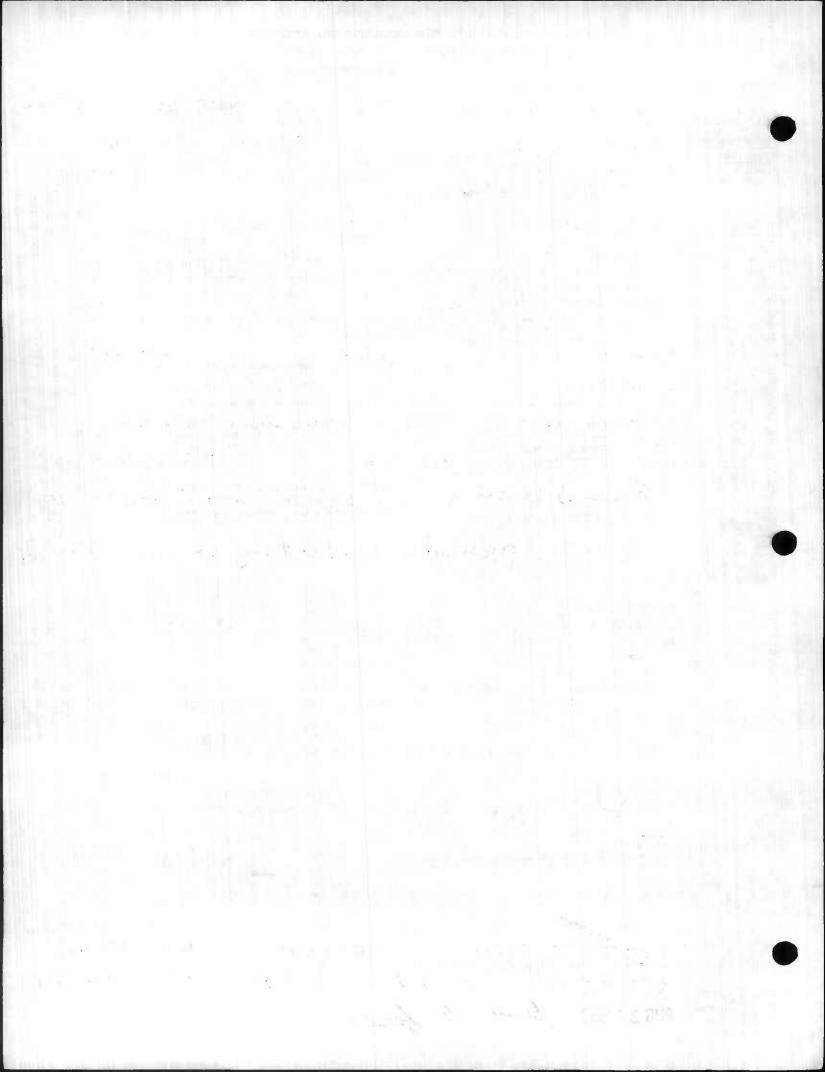
31. Date filed (Month, Day, Year)

AUG 2 4 1999

spect Baltimore

Registrar **DHMH 16 Rev 6/95**

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST Ethel G. Starr 1999 22:53 PM 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Un r 1 Y ar If Un r 2 Hrs 7. Age (in yrs. last birthday) 9. Birthpiace (State or Foreign Days 1□M 21 F Maryland 74 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 4810 Ridge Road 21237 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2₫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Housewife Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Neely Genieve Seufert 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Quaker Hills Ct., Havre de Grace, MD 21078 Karen Schreiber (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery Aug. 24. 1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. dimplications their ceused the death. Do not enter the mode of dying, such as cerdrac or respiratory errest, MD-m, pile cause on each line. 2.1.2.36 Approximate Interval Between Onset and Death RIGHT CEREBROVASCULAR ACCIDENT WITH EMBOLIC 24 HOURS Due to (or as a consequence of): DEHYDRATION WITH INCREASE BUN AND CREATINE 3 DAYS Due to (or as a consequence of): CHRONIC ATRIAL FIBRILLATION YEARS Due to (or as a consequence of) HEMICOLECTOMY SECONDARY TO MESENTERIC EMBOL 3 YEARS Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably ELECTROLYTE IMBALANCE 24a. Was en autopsy 24b. Were eutopsy findings available prior to HYPOPROTEINEMIA completion of cause of death? 25. Was case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medicai Examiner

Physician

/Medicai

5. Social Security Number

219-18-8005

10e. Street and Number

10a. State

Maryland

11. Marital Status

Usual Residence of Decedent

Elementery/Secondery (0-12)

12 years

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last

disease or condition resulting in death)

Mark 1

Examiner

Funeral

Director

28a-f show

Director

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filed within 72 hours efter death with the Maryland

Maryland 21215-0020

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Haaith and Mentel Hydene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified as once.

Examiner Physician/Medical þ Completed Be P Certification:

ed by the attending physician and detached for use es the burial-transit The law requires that the death certificate be axecuted signed by certificate has or Attending Physician: this After t death. To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 3

Division of Vital Records, P.O. Box 68760.

State

Medicai 29b. Signeture and title of certifier allo

1 Yes 2 No

27. Menner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

29c. License number D-25886 29d. Date signed (Month, Day, Year)

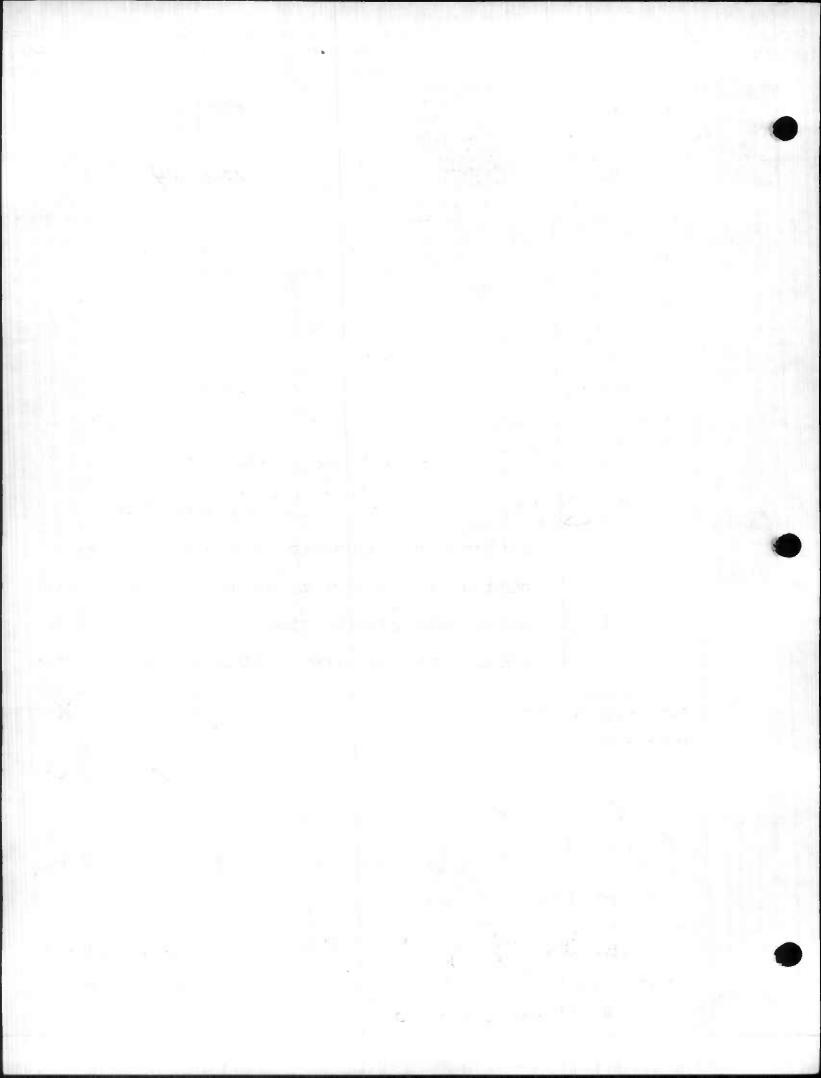
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 AUG2

Registrar

DHMH 16 Rev 6/95 ARMAN





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month August Lucille Clara Steinacker 0017 1999 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL, 900 CATON AUE AYNES BALTIMORE 8. Data of Birth (Month, Day, Ye. JUNE 11, 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months 1 M & F Days 216-16-0725 Yrs. 1922 Maryland Usual Rasidanca of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Southmont Road 21228 USA 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian, Black, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: lf Yas, Giva Year or Detes: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondery (0-12) Coilega (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) William A. Owens Selma Eversmeier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Norbert E. Steinacker/husband 621 Southmont Rd. Catonsville, MD 21228 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Piaca of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Old Salem Cemetery 08/23/99 4 ☐ Donation 5 ☐ Othar (Spacify) Catonsville, MD 21. Signature of Funeral Sarvice Li 22. Name and Addrass of Facility C MacNabb Funeral Home, P.A. Dawn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. MD 21228 Approximate Intervei Between Onset and Death Immediata Causa (Final diseasa or condition resulting in death) Dua to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

physician and s the burial-transit

signed by I

certificate has

After this

Director:

death.

Hospital or At 24 hours efter of

To the Hospital within 24 hours e To the Funeral E

Completed

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To

Certification:

Medical

29b. Signetura and titla of certifier

30. Name and eddress of person who complated cause of death (item 23a) (Type, Print)

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32. Bagistrar's Sonatura

P.O. Box 68760.

Records,

Division of Vital

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r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

the Marylend

hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 is marked other than any injury or other traument.

Baltimore, Maryland 21215-0020

Examiner Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting In deeth) Last Physician/Medical þ

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 24b. Wara autopsy findings aveileble prior to completion of causa of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa referred to medical axaminar? 26. Piaca of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatienf 3 DOA 1 Yas 2 No 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation Injury 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datarmined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred at the tima, dete and placa, and dua to tha cause(s) and manner as stated.

2 Madical Examinar: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) 29a. Certifie and mannar stated

State

Registrar

DHMH 16 Rev 6/95

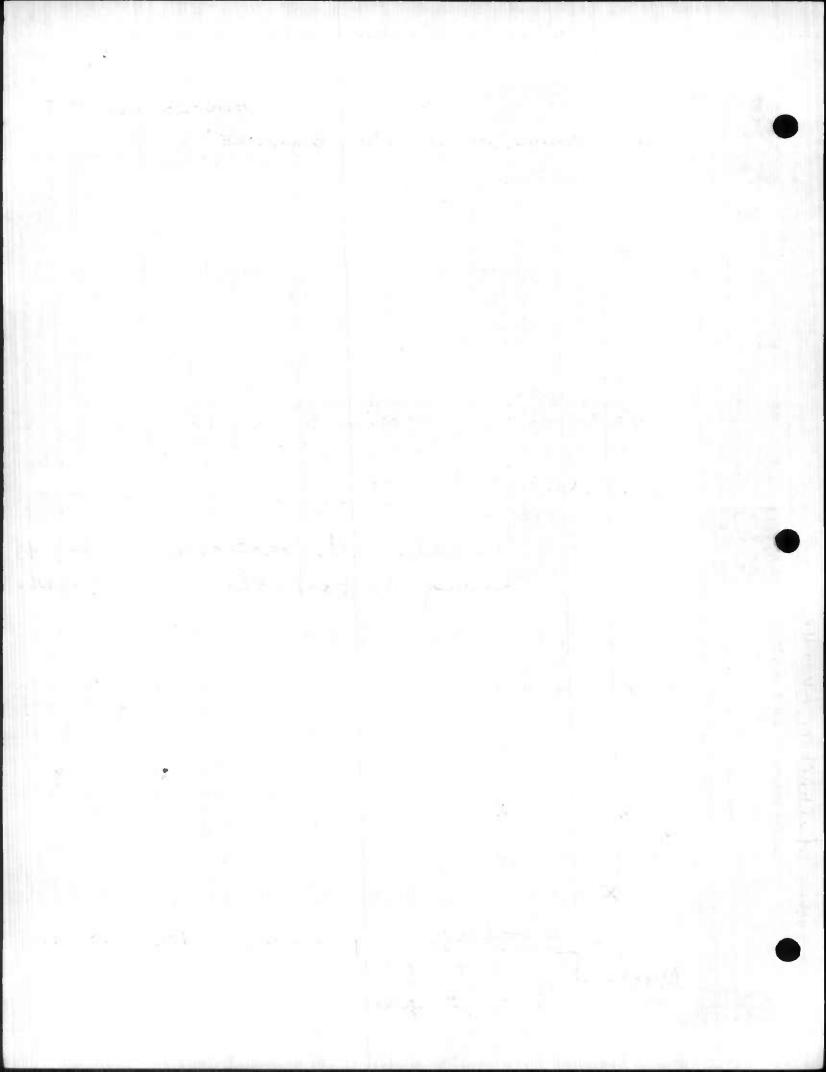
29c, Licensa number

900 Caton Ave.

29d. Date signed (Month, Day, Year)

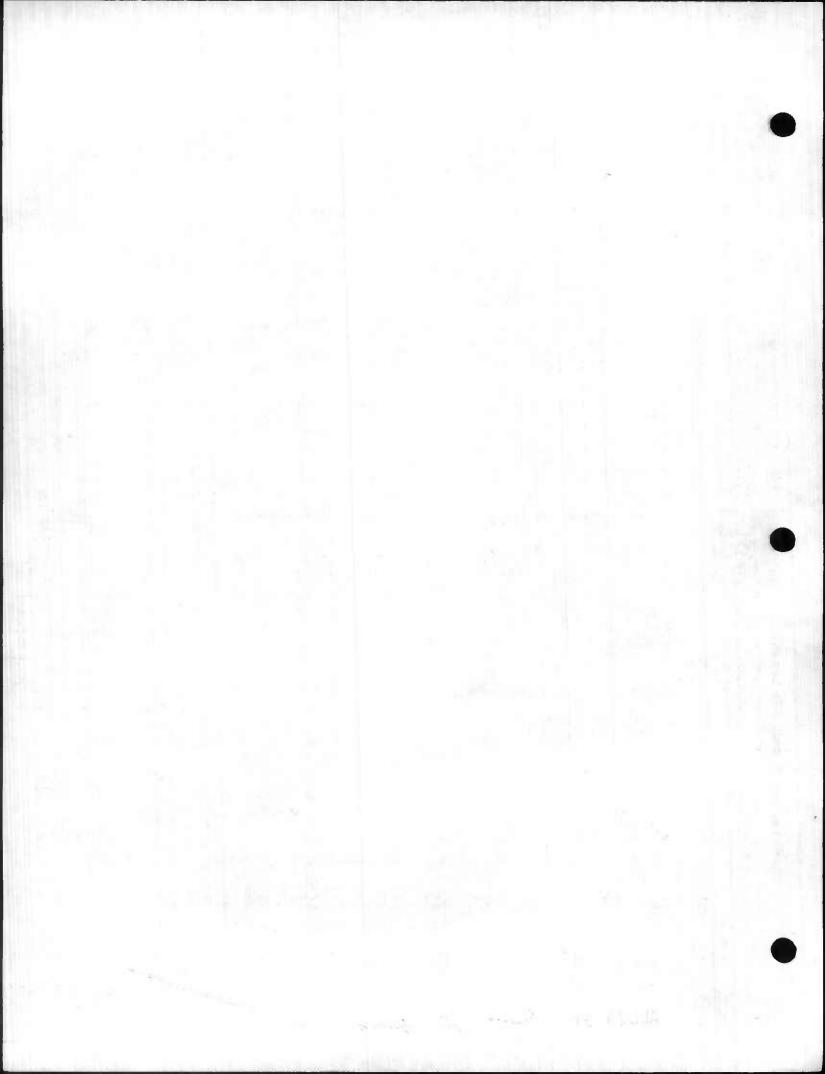
20-1999

Baltimore, MD 21229



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland /	Certificate of		Reg.	337	6600
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vith the Mar	10e. Street and Number		altimore 101. Zip Code		10g.	Citizen of What Cou	1 ☐Yes 2 ☐ No
UZU urs after death v all, or flems 23	3406 Callaway At 11. Maritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Milovorced	Zenue Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 X No If Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Special, Mexican, Puerto F	city Yes or No- lican, etc.)	USA 14. Race - Americ Bleck, White, Specify: B1	
2121 d within glene. or then	15. Decedent's Educe (Specify only highest grade Elementary/Secondery (0-12) 17. Father's Neme (First, Middle, Last)	Completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Laundry Wo	during most of working d)	9	Nind of Business/In	
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Baltimo pemit. Page Department of Important: If any Injury or	21. Signature of Funeral Service House	Mc Donald	22. Name and Addre	ess of Fecility On Societ Verick Rd	y of Md	., Inc.	
Physician /Medical Examiner between and street be swearded as the buriel-transit	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.		consequence of):				
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law requir has been s je 2 should	Doments				24a. Wes an au performed	7 av	ere autopsy findings railable prior to empletion of cause death?
= = = = 0				26. Place of Deeth	1 ☐ Yes (Check only one)	2 N/No 11	Yes 2 No
S S S S S S S S S S S S S S S S S S S	1 ☐ Yes 2 No Ho	28a. Date of Injury 28b.	Time of 28c. Inju		e 5 Residence 8d. Describe how in	e 6 □Other (Special njury occurred	(y)
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affert completaly filled in by the funeral Medical Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
To the Hospital or within 24 hours efte To the Funerel Dir completely filled in Medical Cart	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	tian: To the best of my knowledger; On the basis of examination are and manner steted.	e, death occurred at the ti nd/or investigation, in my o	me, date and placa, e opinion, deeth occurre	nd due to the cause d at the time, dete	e(s) and menner as a end plece, and due t	stated. o the cause(s)
To the common of	29b. Signeture and title of certifier	Bronne	29c. Licens			Dete signed (Month,	
	30. Name and address of person who com	pleted cause of deeth (Item 23a)	(Type, Print) CL Bulcan	1000 Ac	y Ba	(45 more)	MID ZIZM
State Registrar	31. Dete tiled (Month, Dey, Year) AUG 2 4 1000	32. Registrer's Signature	1			,	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month August 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location () Deeth Lockhart ORIST ! If Under 1 Year 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Date of 1□M 20%F Days Hours Pennsylvania 192 - 14 - 2468 Usuel Residence of Decedent 75 Yrs. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21050 11. Meritel Stetus Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2XNo Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumeme) 19b. Mailing Address (Street and Number or Rural Poute Number 19e. Informant's Neme/Reletionship (Type, Print) OM 20a. Method of Disposition 1 Seuriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 23 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Seneral Service Lic Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart felture. List only one cause on each line. Approximete Intervat Between Onset end Deeth Immediate Cause (Finel HASCUD disease or condition resulting in deeth) Due to (or es e consequenca ot): Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting In deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yas 2 ☐ No 24b. Were eutopsy tindings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 A No 1 ☐ Yes 2 PCNo 25. Wes case reterred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Physiclan /Medical Examiner

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/Medical

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Funeral

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Hygiene.

Pages 1 and 2 should be filed nent of Heelth end Mental Hygi-int: If Item 27 is marked other

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injury or

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Examiner

burielphysician the buriel Records, P.O. Box 68760 á should be deta cate hes certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Physiclan/Medical þ Be Completed Medical Certification: To

27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

29b. Signeture end title ot certifier

Registrar

State

who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of person,

Registrer's Signature

28a. Dete of Injury (Month, Dey Year)

28b. Time of

Placa of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes

2 🗌 No

28d. Describe how injury occurred

28t. Location (Street end Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1999

31. Dete tiled (Month, Dey, Year) AUG 2 4 1999

5 Pending

investigation

6 Could not be determined

DHMH 16 Bay 6/95

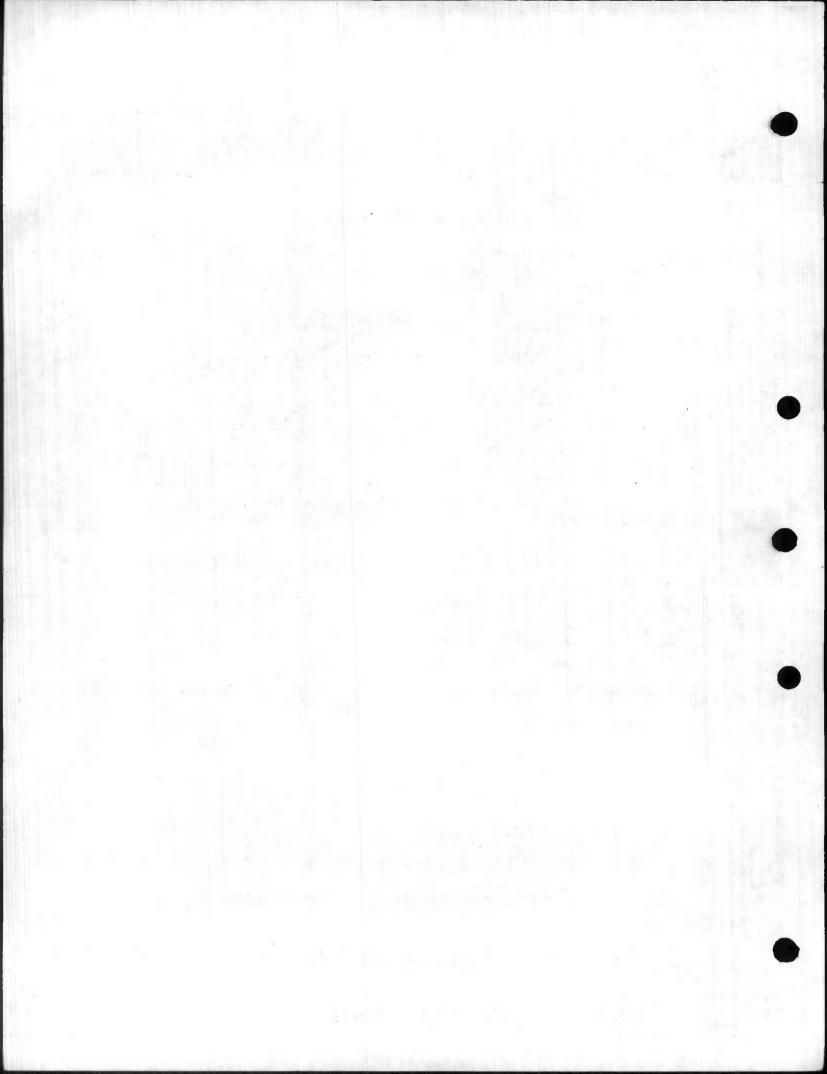
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Please Type or Print in Black Indelibie ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	s Name (First, Middle, La	st)					2. Date of Dea		3. Time	of Death
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4a Facility N	ame (If not institution on		mall		4th Cit	v. Town, or I		At Count	17/1	700
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10e Street a	nd Number							On Citizen of I	What Country?	
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3 □ Wido	r Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ More in Yes, Give Year or Dates:	in U,S.				pecify Yes or No- p Rican, etc.)	Bla	ck, White, etc.	L
	15. Decedent's E	ducation	16a. De	cedent's Usua	al Occupation		. 1	16b. Kind of B	usiness/Industry U	nK
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	nt's Name/Relationship (Type, Print)	19b. M	eiting Address	(Street and N	lumber or Ru	ral Floute Numbe	r, City or Town,	, State, Zip Code)	
Dela	sto A Z	mall-wife	5.3	101 H	aslia	Aug.	Da Ho	Ald.	21215	
- 10	of Disposition	20	b. Place of Di	sposition (Nam	ne of		Date	20c. Location	- City or Town, State	
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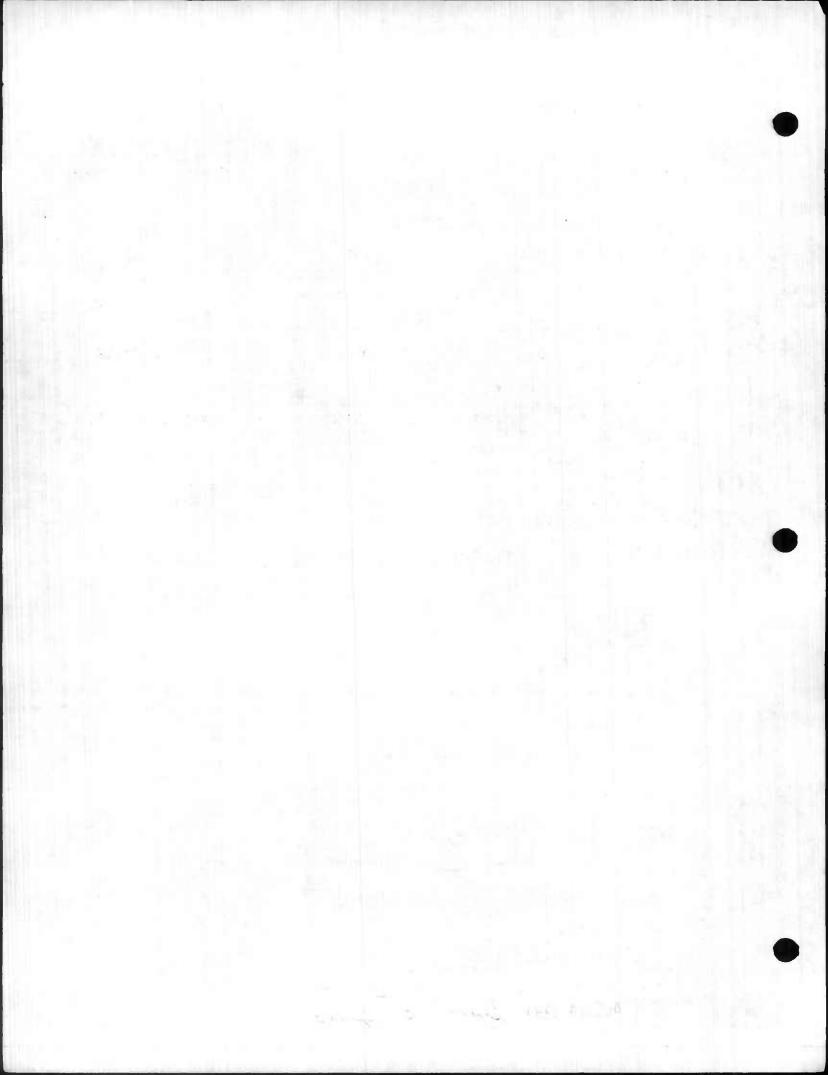


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certi	ficate	of	Death	

SCHNEIDER	2		Ce	rtificate d	of Deat	th		Reg. No.	3 6	20004
	1. Decedent's Name (First, Middle, L	est)					2. Date of De		Vone	3. Time of Death
Physiciar /Medica	CHARLES SCHNET	DER					Month AUGUS	Day ST 22, 1	.999	04:51 AM
Examine	do Conilla, Nama /// not institution of	ve street and number)			4b. City,	Town, or L	ocation of Deal		y of Death	
	GOOD SAMARITAN	HOSPITAL			BAI	TIMOF	Œ			N/A
Funeral		Sex 7. Age (In)	rrs. last birthday	If Under 1 Ye		der 24 Hrs.	8. Date of Bi (Month, D.	rth av. Year)	9. Birth	place (State or Foreign intry)
Director	104-30-0729	% M 2 □ F 59	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		5/17/			YORK
P .	Usual Residence of Decedent 10e. State 10b. County	100	City, Town or Le	nestion						10d. Inside City Limits
aho a										1 ☐ Yes 2 ☒ No
vith the Mar or 28a-fal	MD BALTI 10e. Street and Number	MORE	CARNEY					40 000 4		V = 1
A S S S		COLUMN		10f. Zip Cod				10g. Citizen of		ntry?
0020 hours after death with the Maryland ural', or thems 23s or 28s-f show at Examinar must be notified at	12 B FITZGERALI		-116 140	212		Od-i-2 (C-	anife Man on N		SA	ican Indian,
ther de	11. Marital Status 1XXNever Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	10,5.	Was Decedent If Yes, specify (Cuban, Mexi	can, Puerto	Rican, etc.)		ick, White,	
020 urs eth		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X	No Spec	ify:		Specia	y: will t	നമ
21215-0020 d within 72 hours ef giene. rr than "natural", or to Middell Even			16a Dece	dent's Usual Oc	cupation			16b. Kind of E	WHI Jusiness/Ir	
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be filed half Hyging dother avant, if		1)				ther's Nam	e (First, Middle	, Maiden Sumai		
ylan ylan ould be ould be Mental arked o arked o					U	NAVAI	LABLE			
TO SE DE	19a. Informant's Name/Relationship			ng Address (Str	reet and Nui	mber or Rui	ral Route Numb	ber, City or Town	, State, Zi	p Code)
도들이노	MARLENE CONLEY	GIRLFRIEND	12	B FITZG	ERALD	COUR	r BALT	IMORE,	MD 2	21234
ges 1 and of Health	20a. Method of Disposition		b. Place of Dispo	sition (Name o	f place)		Date	20c. Location	- City or T	own, Stata
트 집 등 부 >	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		METRO CR			. 8	/24/99	CATONS	VILLE	, MD
Baltimore, permit. Pages 1 a pepartment of Hee Important: If item any Injury or othe page.	21. Signature Funeral Service Lice	nsee		2. Name and Ad		cility				
m sees	Hothers	Hades		HE JOHN 521 LOC				P.A. WSON, MI	n 21	286
	23a. Part 1. Enter the disease, or cor shock, or heart tailure. List only	nplications that caused the d							21	Approximate
Physician	snock, or near tallure. List one	one cause on each line.							1	Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	1411-1000	C1 770 C	01.00	ani:	NAS.	aun O	LSEDSE		
Examiner	resulting in death)		o (or as a conse		300010	/ V -) (way y	Menale	1	
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oerflicate be assocuted ding physician and as the burial-transit	that initiated events resulting in death) Last	C. Due to	o (or as a consec	juenca of):					1	
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. 0 0 0	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause	given in Pa	irt I.	23b. Did	tobacco use co	ontribute (to the cause of death?
P. C							10	Yes 2 No	3 Pro	obebly 4 Unknown
S & & & &									1	
COTO requir been s should								s an autopsy ormed?	81	Vere autopsy findings vailable prior to
2 2 8 9							TAP	been,		ompletion of cause f death?
The law requirecte has been signed.							10	Yes 28 No	1	Yes 2 No
Of VItal Physicien: The Physicien: The Continue of the Conti	25. Was case referred to medical examiner?				26. PI	ace of Deal	th (Check only	one)		
Physic physic string of the st	Ho Yes 2□ No		ER/Outpatie			Nursing Ho	ome 5□Res	idence 6 🗆 Ot	her (Speci	ity)
Division of Vital or Atlanding Physician: T free death. Director: After this certificat i in by the funeral director, p	27. Manger of Death	28a. Date of Injury (Month, Day Year	26b. Time o Injury		njury at Work?		28d. Describe	how injury occu	rred	
DIVISION C tal or Attanding P ta after death. al Director: After t ied in by the funeri Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I			М	1 ☐ Yes 2	□No				
DIVIDATE AND STREET	3 Suicide 6 Could not l 4 Homicide determined		t home, farm, st ecify)	reet, factory, off	ice		28f. Location City or To	(Street and Num wn, State)	ber or Rui	ral Route Number,
C a liber										
Division of Vital Re To the Hospital or Atlanding Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Pi (Check only one) Medical Exa	nysician: To the best of my li miner: On the basis of exam								
thin 2 the of the		and manner stated.		20a Lio	ense numb			29d. Date sign	ad (Month	Day Year)
T 1 5 8	29b. Signature and title of certifier	Wash	(1)		ME			AUGUS		
	Munte	my me		1 00	T.III			70002	- 22,	100
	30. Name and address of person who	completed cause of death (I								
	31 Date fled (Most) Day Vot	D D- CORCh		Penn St	reet,	Balt	imore,	Marylan	d 212	201
State Registrar	31. Date filed (Month Plax Year)	1999 32. Relgistrar's Sig	w L	Inn	11					
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 5:00 esa 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death a Ke NIA 2 Saltimore If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days Hours Months 215-18-5806 10 M 201 8 Usual Residence of Decedent 10b. County 10c. City, Town pr Location 10d. Inside City Limits N 1 12 Yas 2 No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yes 2 HNo Specify: 3 Widowed 4 Divorced Blac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aims Examiner Social 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) tannie. (Type, Prim) Grand Her 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 02 timore, Md. 21216 Bake 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cornetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) National em. aure! 21, Signature of Funeral Service Ligaria 22. Name and Address of Facility JOSEPH L. RUSS neral 2222 worth ave. Baltimore Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disaasa or condition resulting in death) La cenan Due to (or as a consequence of):

Physician /Medical Examiner

Department of Important: If any injury or ansa.

Physician

/Medical

Examiner

Funeral

Director

28a-1 must be notifi-

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Pages 1 and 2-ghould be filed within 72 hours after neit of Health and Mental Hygiene.

ent if Item 27 is marked other than "matural", or ite ury or other traumatic event, the Medical Examine

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

certificate has

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To the Hospital within 24 hours a To the Funeral C

or Attending

funeral director,

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filled in by

Medical

the Maryland

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10a. Stata

Director

Funeral

Completed by

Be

MISS

The law requires that the death certificate be executed and use as the Due to (or as a consequence of):

29d. Date signed (Month, Day, Year)

Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas & No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? ANatural 5 Pending investigation 1 TYes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

5046

30. Name and address of person who completed cause of death (Ren 23a) (Type, Print)

Hman

Registrar

31. Date filed (Month, Day, Year) State AUG 2 4 1999

29b. Signatura and titla of certified

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ician	#23 PART I. 27 PER M 1. Decedent's Name (First, Middle, I Clayton D. Sh	Last)	- JW CC-				2. Date of De Month	Dey	Yeer	of Death
dical	4a Facility Name (If not institution,		el .			4b. City, Town, or	AUGUST) PM
niner	HARBOR HOSPITAL	ive street and number	,			BALTIMOR		ve. County	or Death	
ral or	5. Social Security Number 219-74-0373	Sex 7. A	ge (In yrs. la 4]	st birthday) Yrs.	H Under 1 Yes Months Day			1958	9. Birthplace (Stet Country) Mary Land	e or Foreign
-	Usuel Residence of Decedent 10a. Stete 10b. County Maryland N/A			Town or Loca					10d. fneide	City Limits
Director	Maryland N/A		Das	CHIOL	101. Zip Code			10g. Citizen of		53 2 110
al Di	2374 Seamon Ave	nue Apt A			2122			U.S.A		
by Funeral	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Yeer or Dates:	No		es Decedent o Yes, specify Co □ Yes 2Ñ N	f Hispanic Origin? (uban, Mexican, Pue lo <i>Specify</i> :	Specify Yes or No to Rican, etc.)	o- 14. Rac Ble Specify	ck, White, etc. Black	
Completed by	15. Decedent's (Specify only highest s Elementery/Secondary (0-12)	Education grade completed) College (1-4or	5+)	(Give k		supation ne during most of wo ired)	orking		usiness/Industry	
	17. Father's Neme (First, Middle, La	st)		Mai	nager	18. Mother's Ne	me (First, Middle			
To Be	Freddie D. Shaw					Mildred	M. Rob	inson		
	19e. Informent's Neme/Reletionship Loretta Johnson/			19b. Meiling 2374	Address (Stre Seamon	et and Number or R Ave, Apt	A Balti	more, Ma	, Stete Zip Code) 1 ryland 21	225
	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Donation 5 ☐ Other (Spe		COI	netery, creme	tion (Name of story or other p le Vete		Date 8/23/9		City or Town, State Sville, Md	
9000	21. Signature of Fugurel Service Lig 23a/ Pert1. Enfer the disease, or co shock, or heart feilure. List on	N	J	T.7.*	11: (ress of Facility Brown (Community	y Funera	1 Home	21217
Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	a. PNEUMOCO	Due to (or	NINGITIS as a consequ	ence of):				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
edical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		is a consequ					***	
ician	Part II. Other significant conditions	contributing to death	but not result	ing in the unc	derivino cause	given in Pert I.	23b. Did	tobacco use co	ontributa to the caus	e of death?
by Physician/M								Yaa 25 No	3 Probably 4	
Completed b								s an autopsy ormed?	24b. Were autops evailable pric completion of of death?	of cause
6	25. Wes case referred to medicat					26. Place of De	eth (Check only	Yes 2□No	1 ☐ Yes 2	IU No
ToB	examiner?	Hospital: 1 Inpat		R/Outpatient	SENDOA	Other: 4 Nursing	Home 5□Res		ner (Specify)	
Certification:	27. Manner of Death 1 \(\)\text{ Neturel} 5 \text{ Pending} \text{investigat} 3 \text{ Suicide} 6 \text{ Could not} \text{.}	ha	ay Year)	28b. Time of Injury		Yes 2 No		how injury occur		
	4 Homicide determine	rd 288. Place of In	ijury - At hom tc. <i>(Specify)</i>	ne, ferm, stre	et, factory, offic	×9		(Street and Numi own, Stete)	ber or Rural Route N	umber,
		Physician: To the best aminer: On the basis of end manner s	of examination							e(s)
dica					29c. Lice	nse number		29d. Date eigne	ed (Month, Day, Year)
Medical	29b. Signature and title of certifier		100							
	> (Mayore	he Yhullo completed cause of	death (ftem 2	23a) (Tvpe. P		ME		AUGUST	18, 1999	

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Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month CHESTER SHERMAN NELSON 4b. City, Town, or Location of Death 6: 15 AM 1999 4a Facility Name (If not institution, give street and number) 4c. County of Death Hospital HOPKINS Baltimore Janus N/A If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Feb. 22, 1925 If Undar 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F Months Davs 218-14-6868 74 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location XX Yes 2□No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21211 3451 Keswick Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ₩ es 2 □ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Spacify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Self-employed Electrical 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middla, Last) William Daniel Sherman Emma Berwager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3451 Keswick Road, Baltimore, Maryland 21211 Carol Marks Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley Memorial 8/20/99 Cockeysville, Maryland 4 □ Donetion 5 □ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

death with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show emy fujury or other treumstic event, the Medical Exert in training in cutting an once.

Baltimore, Maryland 21215-0020

physician and the bunal-transit for use es signed by the a

Examiner

Physician/Medical

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Certification: To

Medical

K. A. Baltour

AUG 2 4 1999

31. Date filed (Month, Day, Year)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, bloods is certificete has director, page 2 Hospital or Attending Physician: this After this funeral n 24 hours after deeth.

Ne Funerel Director: Alpletely filled in by the fu deeth.

22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland litions thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, cause on each line. Approximeta Interval Between Onset and Death Immediate Ceuse (Final disease or condition rasulting in death) Infarction 2 days · Acute Myocardial Due to (or as a consequence of): 2 days Wrosepsis Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Denentra Alzheimers

24b. Wera autopsy findings aveilable prior to completion of causa of death? 1 Yas 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, end dua to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number

souks

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32 Registrar's Signature 6. In court East. odentar Rea

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24a. Was an autopsy

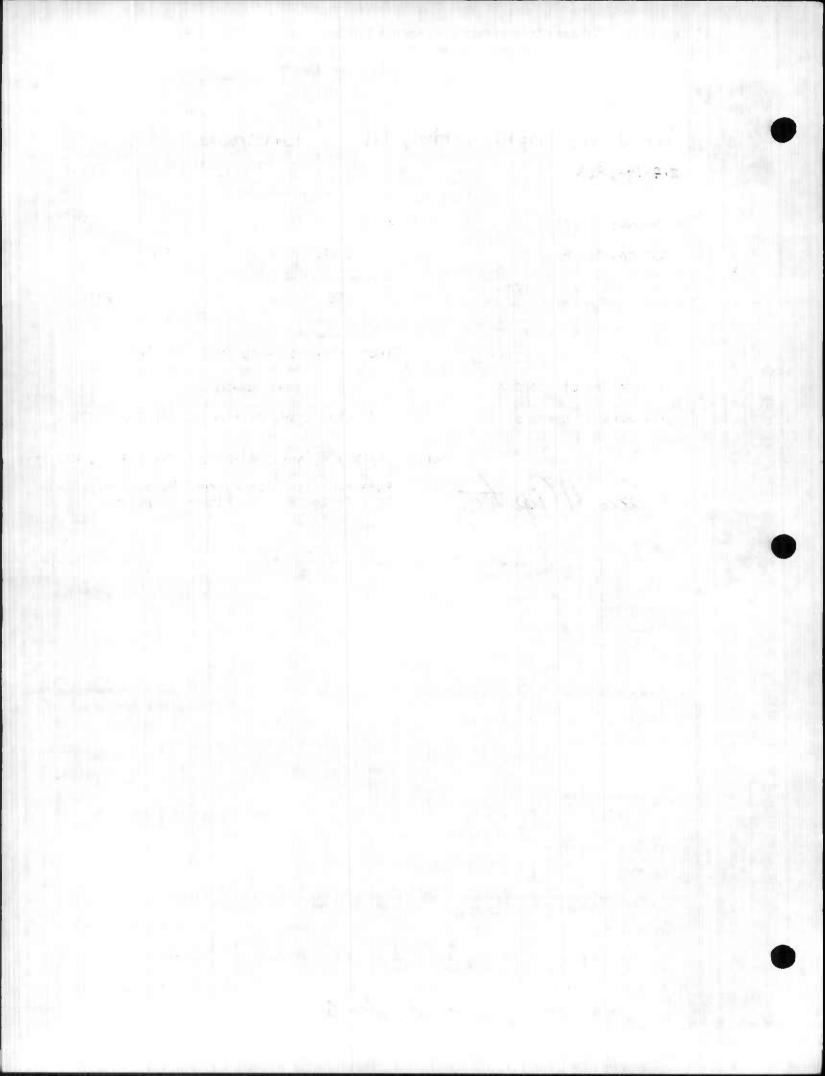
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State Registrar

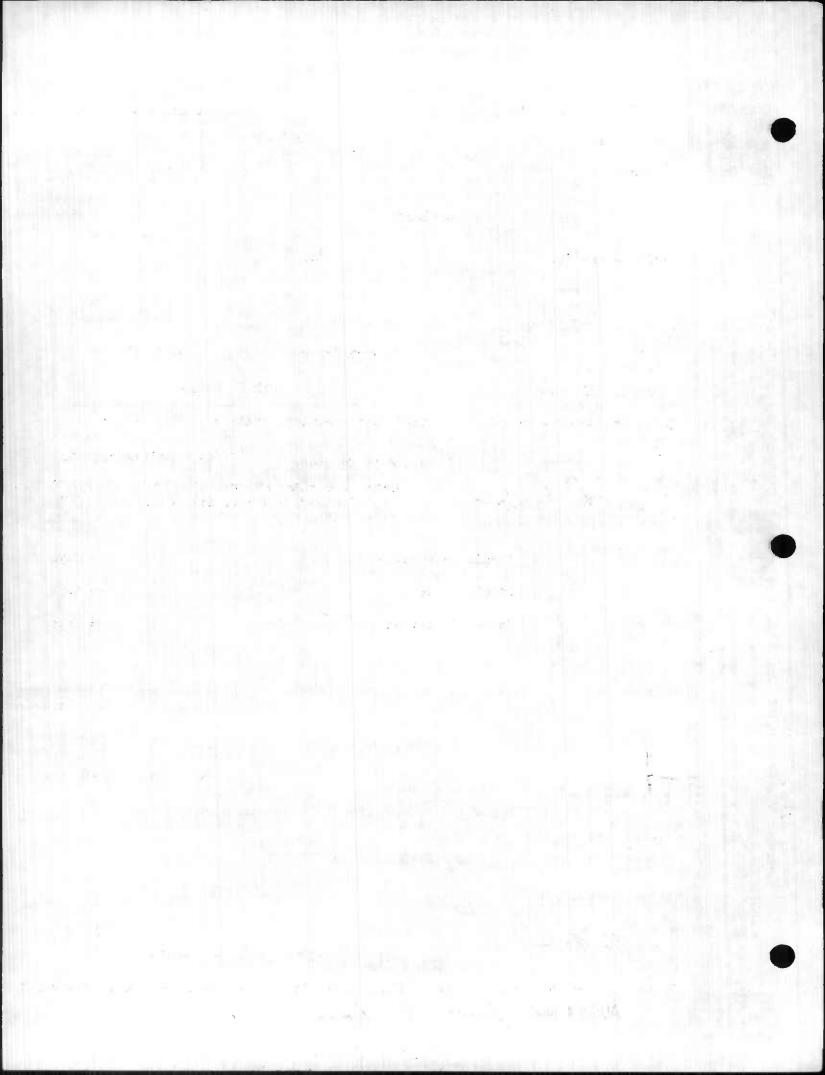
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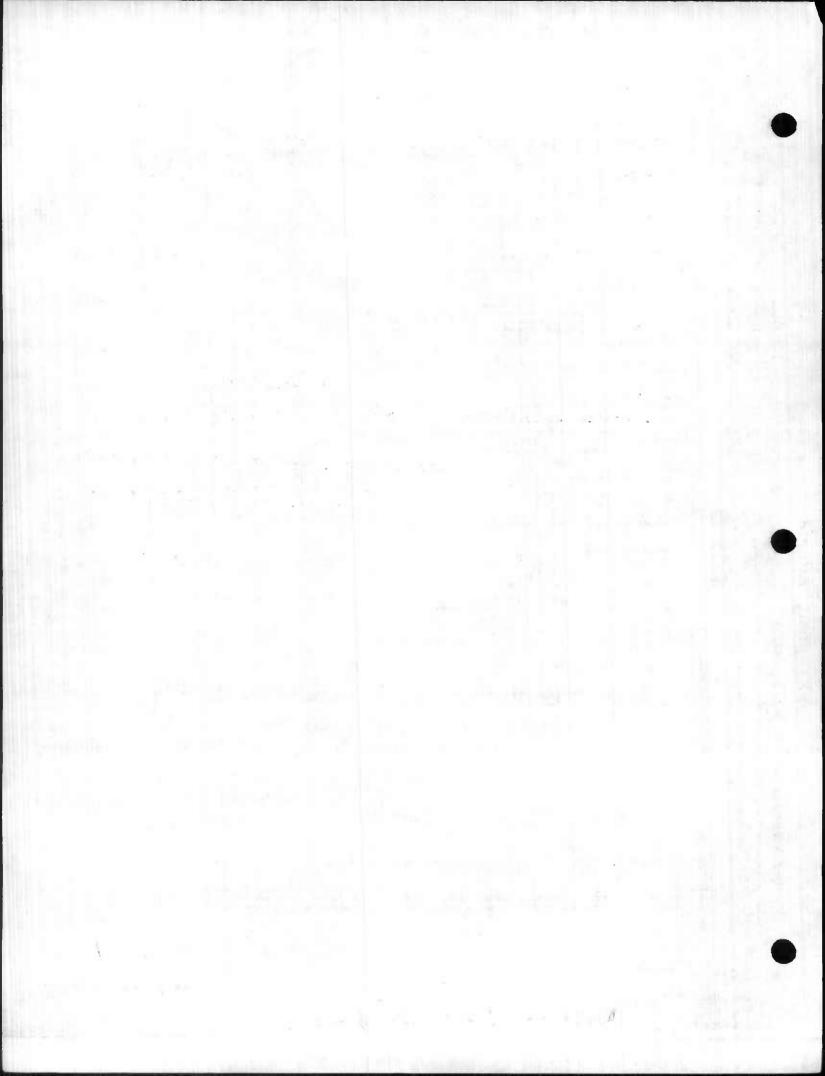
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ctor	MD	N/A		Bal	timore								1 X Yas 2 □ N
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or other us	20e. Method of Dis	sposition		20b.	Placa of Disp cematary, cra	osition (Na	ma of			Data	20c. Location	- City or Tov	wn, Stata
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No.		State of Ma	-	Certificate of			Reg. No.	9 2	26600
Physician /Medical	Decedent's Name (First, Middle, La.		Mae Tho	mpson		2. Date of De Month	Day	Year 999	3. Time of Death 2310
Examiner	4a Fecility Name (If not institution, giv	e street and number)			4b. City, Town, or L				
	Fallston General				Fallston			rford	
Funeral Director	222-03-2151	□M 2K□F	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Bin (Month, Da April 1	th ly. Year) .2, 1915	9. Birthpl Count De 1	lace (State or Foreign try) aware
P 8 w	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
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or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	try?
23a marga 15 w	6740 Danville A	venue			21222		United	1 Sta	tes
020 rs after death vir. or have 23 barrions mast	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecity Yes or No Rican, etc.)	Specify:	e - America k, White, e	
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Battimore, Maryland 21215-0020 amit. Pages 1 and 2 should be filed within 72 hours all begardness of the process of the state of the st	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		cemetery	Disposition (Name of y, crematory or other pla wridge Mem.	8/	Date 24/99	20c. Location -		
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Physician /Medical	23a. Party. Enter the disease, or comshock, or heart lailure. List only Immediate Cause (Final disease or condition	one cause on each lin	6 .	ot enter the mode of dying	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset end Deeth
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- 0 0 X =	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying cause given	ven in Part I.	23b. Did	tobacco use con	tribute to	the cause of death?
S, P.O. So that the de defined by defined by Physic				-		10	Yes 2□ No	3 Prob	bably 4 Unknown
Cord						24a. Was perfo	an autopsy ormed?	cor	ere autopsy lindings ailable prior to mpletion of cause death?
If Rec						10	Yes 2 No	10	Yas 20 No
f Vitai II	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only	one)		
of Vita Physician: this cartific ral director,	1 ☐ Yes 2 🕅 No	Hospital: 120 Inpatier		patient 3LI DOA			dence 6 Othe		r)
Mag P. After I funers funers	27. Manner of Death Natural 5 Pending	28a. Date of tnjung (Month, Day	Year) 28b. Ti	jury Wo		28d. Describe	how injury occurr	ed	
	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, lan . (Specify)	M 1 m, atreet, factory, office	Yes 2 No	28f. Location (City or To	Street and Number wn, State)	er or Rura	I Route Number,
Division Within Expense of Attention Within Expense Director; completely filled in by the Medical Certifical	29a. Certifier 12 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and	death occurred at the ti Vor investigation, in my o	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as st and due to	ated.) the cause(s)
To the within complete	29b. Signature and title of certifier	4	7-	29c. Licens	se number		29d. Date signed	1 (Month, I	Day, Year)
	> Mark	If Wly	12	d	35520	2	Augus"	tai	1, 1999
18	30. Name and address of person who	2 Nov	-Th	Type, Print) Avenue	Bel A	ir N	lary/a	nd:	21014
State Registrar	31. Date filed (Month, Day, Year) AUG 2 4	32. Registra	r'a Signatura	G. Sport	N		/		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Year August 20, 1999 4b. City, Town, or Location of Death 4c. County of Deeth Carolyn Tippett 12:30 PM 4e. Facility Name (If not Institution, give street end number) 4c. County of Deeth 5 Rognel Avenue Catonsville Baltimore If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 1□ M 2□XF Yrs. 216-28-3095 FEB 25, 1932 New York Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Rognel Avenue 21228 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: 11. Marital Status Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Bookkeeper Social Services 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Sigmund K. Charewich Frances Krause 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Thomas Tippett/son 5 Rognel Avenue Catonsville, MD 21228 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 8/25/99 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility MacNabb Funeral Home, P.A. McDonald 301 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Final 3yrs 2 mos metastatic rectal concer disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funerai

Director

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permit. Pege Department of Important: If eny injury or once.

Baltimore, Maryland 21215-0020

Director

by

Completed

27. Manner of Deeth

1 Naturel

2 Accident 3 Suicide

4 Homicide

29b. Signature end title of cartifier

29a. Certifier

5 Pending investigation

6 Could not be determined

n-a-

Examiner and attending physiclan for use es the buria Physician/Medicai the signed by t by Be Completed 2 Certification:

certificate be executed Box 68760. P.0. Records, Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica ilely filled in by the funeral director, To the Hospital o within 24 hours eff To the Funeral Di compleiely filled Ir

Registrar

VINNE State

Medicai

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print) CTTAV.MO MA Date filed (Month, Dey, Year) 32. Registrar's Signeture AUG 24 1999

900 CATON

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29c. License number

D40850

AVE

1 ☐ Yes 2 ☐ No

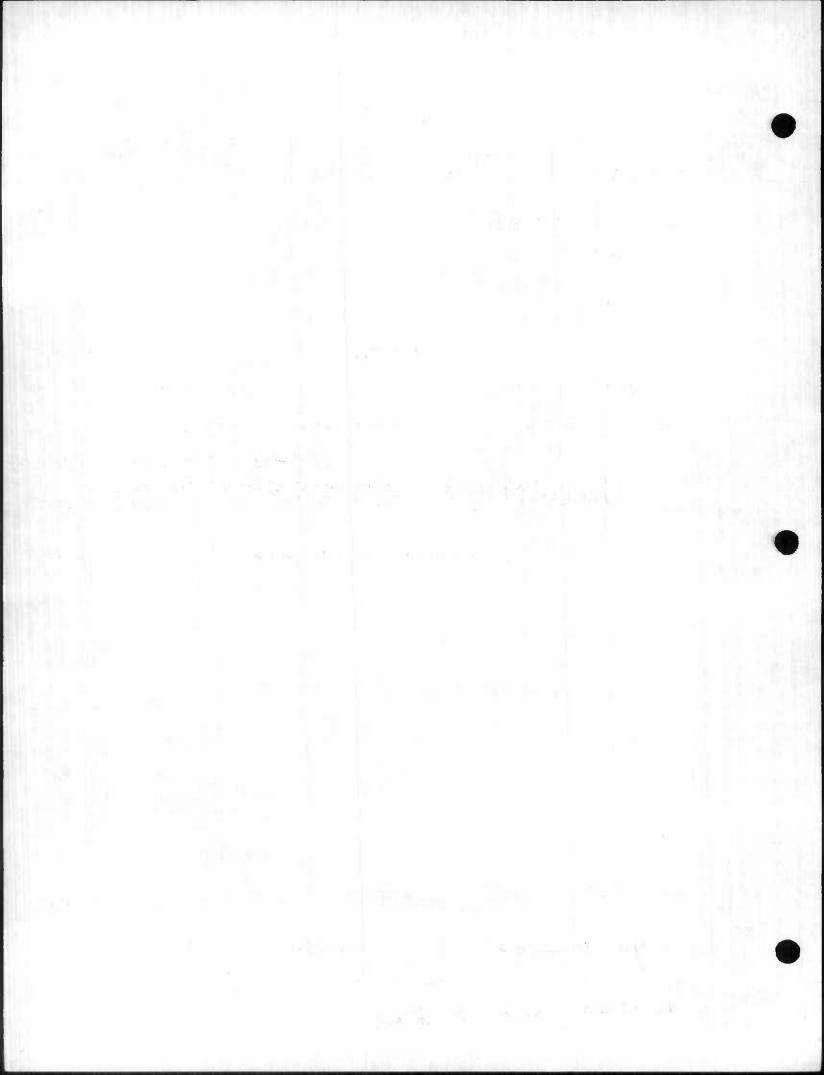
28d. Describe how injury occurred

BALTIMORE MD 21229

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

August 20, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month De Day Veer WILLIAMS DORA 19 1999 11:41 AM 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BACTIMORE JOHNS TOSPITAL H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 10 M 2 F Months 56 LOUISBURG, NC 213-60-3361 Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location N/A Yos 2 No BALTIMORE MD 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A. 21.206 5253 SAYBROOK RD 12. Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 t. Meritel Status Bleck, White, et 1 ☐ Never Merried 2 Merried BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN 8 UNKNOWN 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) IRENE WATT HURLEY WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) MD 21206 5253 SAYBROOK RD, BALTO. CHARLENE WILLIAMS, DAUG. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 DBuriel 2 Cremetion 3 Removel from Stete MOUNT ZION 8-24-99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugural Service License 22. Name and Address of Facility AL HOME HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset and Deeth SEPSIS Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of):

or Attending Physician: The law requires that the death certificate be executed and Box 68760. physician eun USB &S 1 jo Division of Vital Records, P.O. funeral director. this death. To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

must be notified 2

Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiene.

Int. If Itsen 27 is marked other than "natural", or itse

of Health a. vt; if Nem 27 is

Physician

/Medical Examiner

Examiner

Physician/Medical

Completed by

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Certification: To

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29b. Signaffered

Saltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Pert II. Oth	ner algnificant conditions c	ontributing to death but not re	sulting in the underlying	g caus	e given in Part I.	23b. Did tobecco use co	ontribute to the cause of death? 3 Probably 4 Unknown
				_		24a. Was an autopsy performed?	24b. Were autopsy tindings evailable prior to completion of cause of death? 1 Yes 2 No
	ase referred to medical				26. Place of De	eath (Check only one)	
axamir 1 🔲 Ye	. 0	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Ott	her (Specify)
27. Menne t Ne 2 A		28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 □ S 4 □ H	ulcide 6 Could not b determined		nome, ferm, street, fect	lory, of	ffice	28f. Location (Street and Num. City or Town, State)	ber or Rurel Route Number,
29e. Certif (Chec one)	k only 2 Medical Exam					e, end due to the cause(s) and m urred at the time, date and place,	

State Registrar

CHENG!

nd title of certifier

WOLFE STREET

MEDICINE

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

BALTIMORE, MARYLAND

29c. License number

RES-000

29d. Date signed (Month, Dey, Year)

HOUSESTAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Day 20 **Physician** PAROLEE J. WILLIAMS 3:19 PM AUGUST 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTMORE HARBOR HOSPITAL CENTER If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** Months 1 M 2 F 68 Yrs. 240-40-8346 11/11/1930 Director North Carolina Usual Rasidanca of Dacedant with the Manyland r 28a-f show 10a Stata 10b. County 10c. City, Town or Location 10d, insida City Limits 1 XYas 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 21229 U.S.A. 521 Normandy Avenue permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examples invast place. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 [XNo If Yas, Giva Yaar or Datas: 14. Race - American Indian. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: Black p 3 to Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Senior Aid Clerical 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Sadie Dawkins Russell Jeter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 521 Normandy Ave., Baltimore, Maryland 21229
ace of Disposition (Name of Data 20c. Location - City or Town, State Marie Lomax / Daughter 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) 08/25/99 Baltimore, Maryland Arbutus Memorial Park 22. Nama and Addrass of Facility The Derrick C. Jones Funeral Hm. 21 Signatura of Funarai Sarvice Licensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on machine. Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) ACUTE FAILURE RESPIRATORY WEGU Examiner Dua to (or as a consequence of): Examiner LUNG CANCER MONTHS physician and the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disease or Injury that initiated avents rasulting In death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the per signed by the 1 Yss 2 No 3 Probably 4 Unknown CORONARY ARTERIC DISGASE A 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed UTERING CANCER ils certificate has t director, page 2 s 2 No 1 ☐ Yes 20 No or Attending Physician: after death. Director: After this certifica 25. Was cese referred to medical axaminar? Be 28. Placa of Death (Check only ona) Hospital: 1 Anpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No Certification: To funeral 27. Mannar of Death 28d. Dascribe how Injury occurred 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No investigation 6 Could not be 3 Sulcida 281. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 4 Homicida in 24 hour. the Funeral Directory Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the ceuse(s) end mennar as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mennar stated. 29a. Certifian To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and this of certifie 29d. Data signed (Month, Day, Year) 29c. Licansa number RESIDENT 20, 1999 12797 AUGUST 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 300 / STREET SOUTH HANDUER SHWG. MICHA GYAW

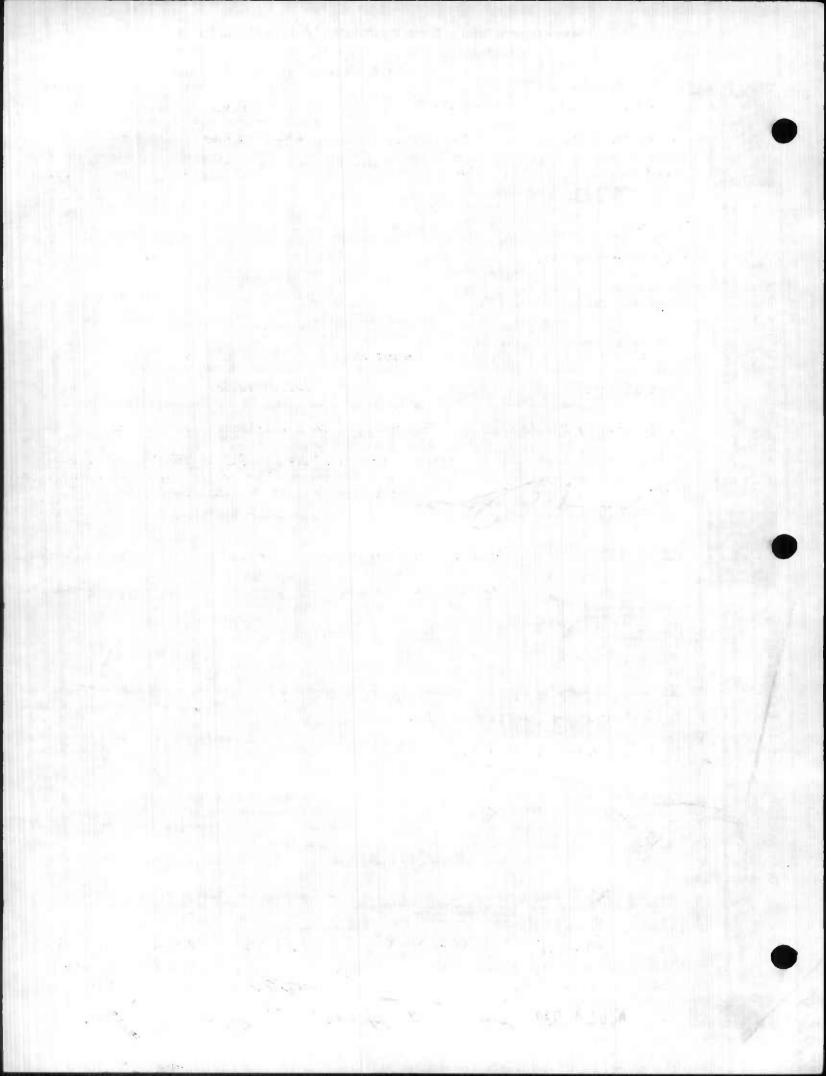
State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) AUG 2 4 1999 32 Registrar's Signature

BALTIMORE

21225



68760 Box P.O. Records. of Vitai Division Hospital

21215-0020

Baltimore, Maryland

State Registrar

completely

(Check only

29b. Signafura and titla of certifier

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E

29d. Data signed (Month, Day, Year)

18,1999

AUGUST

111 Penn Street, Baltimore, Maryland 21201

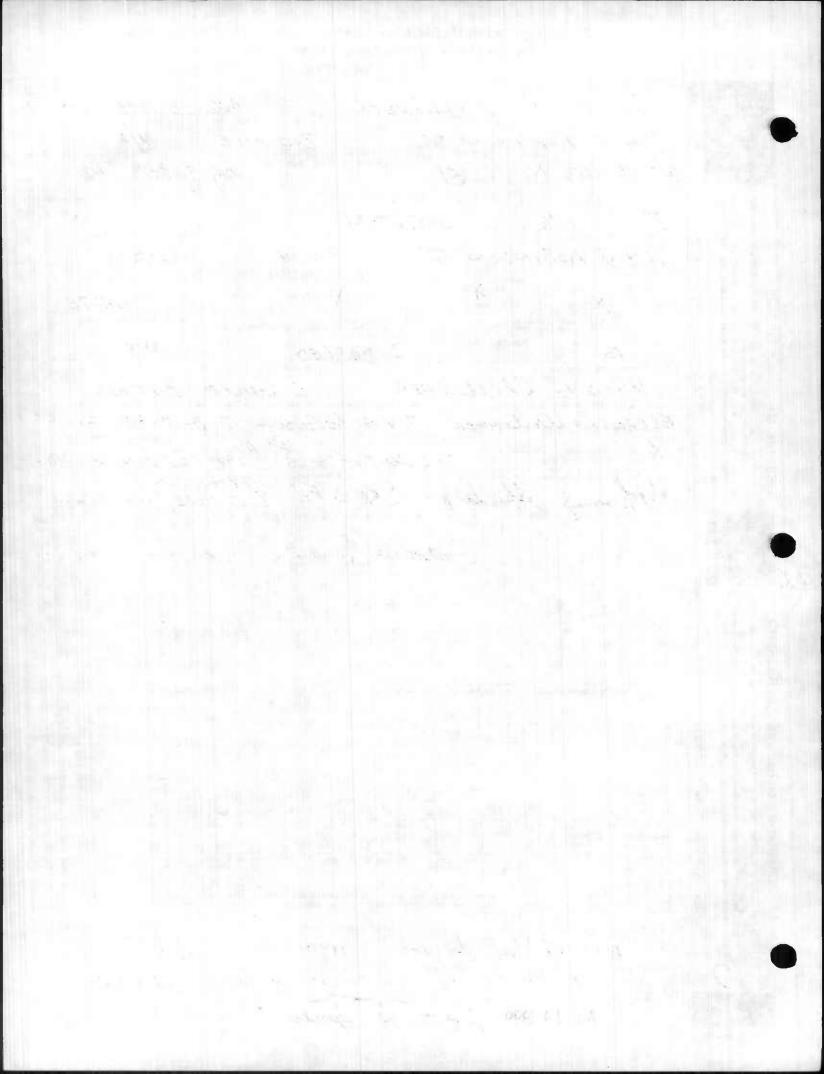
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Irroportant: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified as 805s.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

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Albert Charles Wi

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rles Wrig	ght	State	of Ma	aryland i				lealth a Death		Mental Hy	ygie Reg.		19	26615
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4a Facility Nama (I		n, give street and no Hospital					4	46. City, To Balt:		ocation of Dea	ith	4c. Count	ty of Death	
5. Social Security N 228-90		6. Sex 1∑M 2□ F	7. Ag	e (In yrs. last 43	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Bi	irth y	356	Cour	placa (Stata or Foreign ntry) ginia
Usual Rasidence of	f Decedant													
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19a. Informant's Na	ame/Ralations	hlp (Type, Print)		1	19b. Maitir	ng Address	(Street	and Numb	er or Rur	rai Routa Numi	ber, C	ity or Town	n, Stata, Zij	p Code)
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20a. Mathod of Disp 1 Burial 2 4 Donation	Cramation	3 □Ramoval from	n Stafa	20b. Place cema	e of Dispo	natory or o	ma of other plac	ce)		Data 24/99	200	c. Location	more,	own, State
21. Signature of Fu	n Dub	Donald /	10/)may	$\begin{pmatrix} C \\ 2 \end{pmatrix}$	remat 99 Fr	cion cede	rick I	ety Rd.	of Md., Baltimo	ore	. MD	21228	3
23a. Part1. Enfar fi shock, or has	ha diseesa, or ort failura. List	complications that only ona causa on	caused each lin	tha death. C	o not ent	ar tha mod	le of dyin	ig, such as	cardiac	or respiratory	arrest,		1	Approximate Intervat Between Onsat and Death
Immediate Causa (disease or condition rasulting in death)		a /	rul	Fiple Dye to (or as	60	inst	wt	U	BUR	do				
				Dye to (or as	a conseq	juence of):								

Physician /Medical Examiner

> Medical Certification: To Be Completed by Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

within 24 hours after death. To the Funeral Director: After this certificate has

Division of Vital Records, P.O. Box 68760.

Immediate Ca disease or cor rasulting in da Sequentially list conditions

29b. Signature and title of certifie

Due to (or as a consequence of):
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Dua to (or as a consequence of):

cause, Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in death) Last	cDua to (or as a	a consequence of):			
resulting in death) Last	d				
Part II. Other algorificant conditions of	ontributing to death but not resulting	in tha underlying caus	a given in Part I.	23b. Did tobacco usa co 1 □ Yss 2反No	ntribute to the cause of death
			N in p	24s. Wes an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
				VAYas 2□No	1 AYas 2□ No
25. Was casa rafarred to medical axaminar?			26. Place of Dea	ath (Check only ona)	
1 TyYas 2 No	Hospital: 1 ☐ Inpatiant 2 ☑ ER/0	Outpatient 3 DOA	Other: 4 Nursing H	loma 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigatio	(Month, Day Year)	D. Tima of Injury M	Injury at Work? 1 □ Yes 2 12 No	28d. Describe how Injury occur subject shot	red
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicida determined	28a. Placa of Injury - At home, building, atc. (Specify)	farm, street, factory, of	fice	281. Location (Street and Numb City or Town, State) 130 Ra (Amore, Mil	ber or Rural Routa Number, O Guilford AM
	ysician: To tha best of my knowled niner: On tha basis of axamination a and menner steled.				

29c. License number

O.C.M.E.

State

32. Begistrar's Signatura

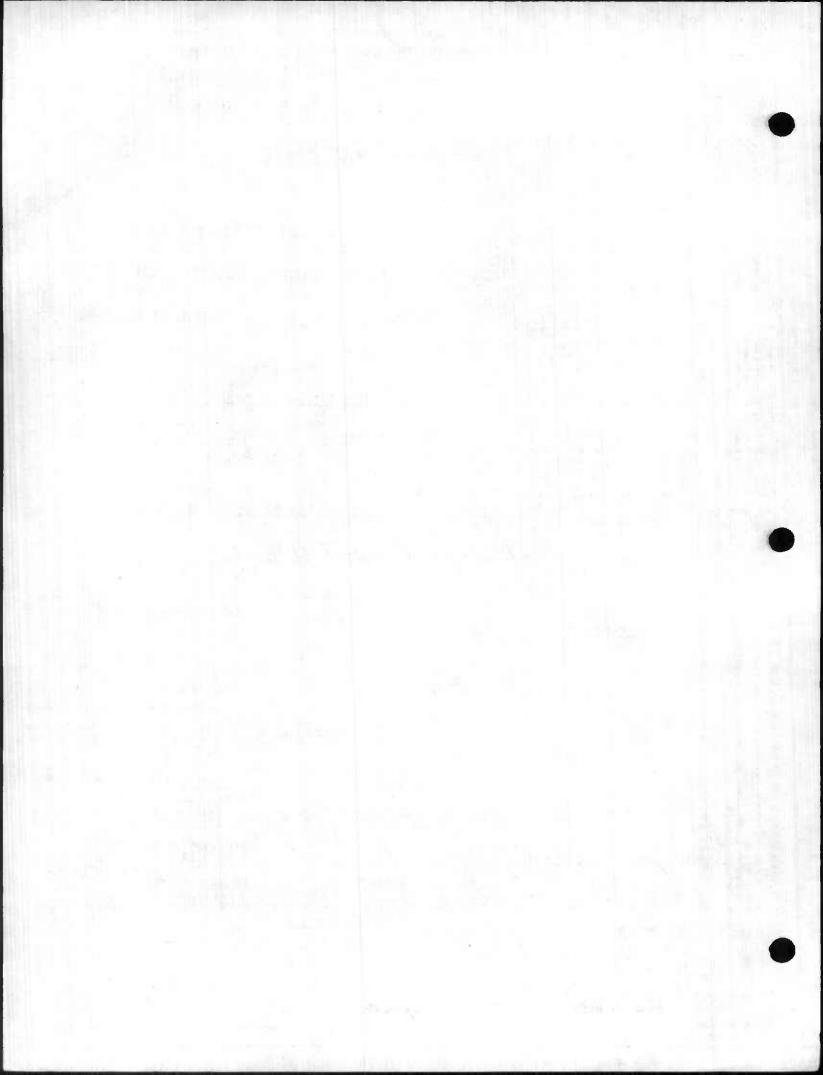
completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

August 22, 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Geraldine Wooden Mais 10:00 AM /Medical 4a Facility Name (If notijnstitution, give street and number) 4b. City, Town, or Location of D 4c. County of Deeth Examiner NA Hospita e Himore 20 Tomore uti 6 Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F 214-56-3540 49 Director 11-19-49 MD Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits ment: If tem 27 is merked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Exercities must be incidied at Ves 2□No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2208 Whittier Avenue 21217 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 34 0 of 1 Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Black Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other secure. Elementery/Secondary (0-12) College (1-4or 5+) Private Duty Options for Senior 12th Grade 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 should be fi Payton Edmond Corrie Wooden 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21217 19a. Informent'a Neme/Reletionship (Type, Print) Linda Makle 2208 Whittier Avenue L. Baltimore, Maryland 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete Arbutus Mem. Pk. Cemi. 08-25-99 Arbutus, MD 4 □ Danetion 5 □ Other (Specify) 21. Signature of Funeral Service Linear 22. Neme end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final INFARCTION 10CARDIAL 5 dous diseese or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burial Physician/Medical Due to (or es e consequence of) 88 980 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 Yea 2 No 3 Probably 4 Unknown signed by GI BUEED py 2 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy peeu has 2 1 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury at Work? Aftar or Attending 1 Netural 5 Pending investigation aftar death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Puneral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafted. 29e. Certifier To the

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DHMH 16 Rev 6/95

atient Known As: Geraldine

Box 68760

P.O.

Records.

Division of Vital

State Registrar

31. Dete filed (Month, Day, Year) AUG24

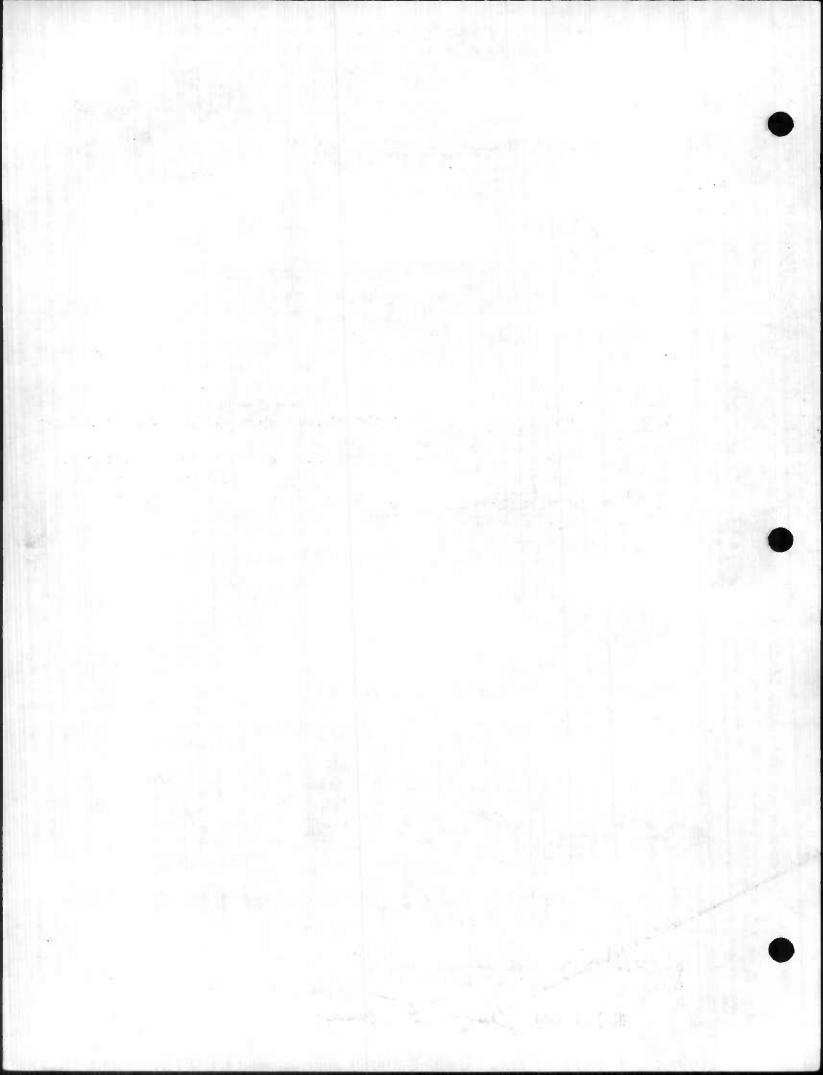
296. Stort

32 Registrer's Signetur

eth (Item 23a) (Type, Print)

29c. License number

29d. Daye signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUSI bar :08 PM 500 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) TOWSON if Under 24 Hrs. 8. BALTIMORE . JUSEPH MEDICAL CENTER If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 1 M 2 F Days Min Months Hours Yrs. MD 214-26-3726 Usual Residence of Decedent 70 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No PARKVILLE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code U.S.A HILL ANE 21234 PUTTY 2304 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: if Yes, Give Year or Dates: ARMY 1 3 ☐ Widowed 4 ☐ Divorced WHITE KOREA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) EQUIFAX INSURANGE 12 CLAIMS 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) WILKERSON LILIAN CARROLL G. M. UBER 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE PARKVILLE, MD. 21234 Date 20c. Location - City or Town, State JOAN C. WILKERSUN 2304 PUTTY HILL AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition AUG 24 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 PARKVILLE MOREYAND MEM. PARK 22. Name and Address of Facility EVAUS FUNDER CHAPET 21. Si atura of Funeral Seprice Licenses were malo 8800 ITAEFORD ED. PARKVILLE, MD. 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feiture. List only one ceuse on each line. Approximete Interval Between Onset and Death immediate Cause (Final disaese or condition resulting in deeth) Due to (or as a consequence of) en052 Due to (or as a consequence of) 0 Sev 23 Dua to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 1 Yes 2 No 3 Probably 4 Hiknown

Physician /Medical Examiner

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Division of Vital Records.

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Maryland 21215-0020

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Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical that initiated events resulting in death) Last 88 USB the by

> 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner:
>
> 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ EN/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

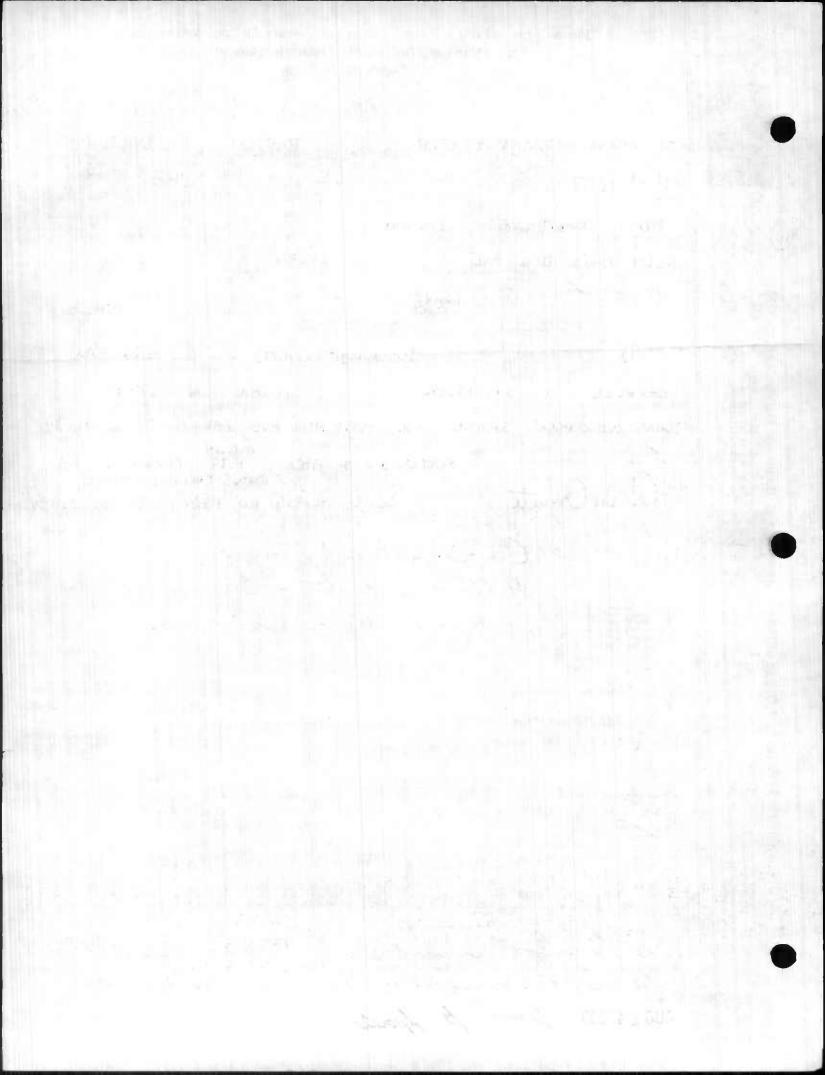
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and fitte of fortifier 29d. Date signed (Month, Day, Year)

30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) // / S > 1

MMI 132 les ONNE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

AUG 2 4 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ne (First, Middle, Last) me (If not institution, giva street and number) 4b. City, Town, or Location of Dr 8. Date of Birth (Month, Day, cial Security Number Bumplace (State or Foreign Gountry) 1 M 20 F 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No MD APT 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Race - American Indien, Black, White, etc. rove 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Balto CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) U SOr Goins Wilson 19a. Informant's Name/Relationship (Type, Print) Mr. Moses W. Himore, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation altimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222 W. North for the disease, or complications that caused the deeth. Do not enter the mode of dying, such as heart tailura. List only one cause on each line. Cardiopulación horast Immediate Cause (Final 7 min disease or condition resulting in death) Multiple Organism sens, - VRE, MRSA ~ week entially list conditions , leading to immediat . Enter Underlying) (Disease or injury Acute Renay Fallure ~ week

Physician /Medical Examiner

permit. Pege Department of Important: H any Injury or once.

Physician /Medical

Examiner

Funeral

Director

Peges 1 and 2 should be filed within 72 hours after death with the Maryland and to Healh and Mental Hyglene.

ant: If them 27 Is marked other than "natural", or items 23s or 28e4 show ant: If them 27 Is marked other than "natural", or other traumatic avent, me thinging I manifest man

Baitimore, Maryland 21215-0020

Be Compieted by Funeral Director

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physician and s the burial-transit To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dis

or Attending Physicien: The lew requires that the deeth certificate be associted

Division of Vital Records, P.O. Box 68760.

Examiner

that initiated events resulting in death) Last	,	or as a consequence of	,		sever 1415
Part II. Other significant conditions of	ontributing to death but not re		g cause given in Part I.	23b. Did tobecco use co	all Probably 4 Unknow
	,	'		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	/		26. Place of D	eath (Check only one)	
1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Oth	er (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occur	red
3 Suicide 6 Could not be detarmined	28e. Place of Injury - At I building, etc. (Spec	home, ferm, street, fec	tory, office	28f. Location (Street and Numb City or Town, State)	per or Rural Routa Number,
				ce, and due to the cause(s) and ma curred at the time, date and place,	
29b. Signature and titla of certifier			29c. License number	29d. Date signe	d (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 2 4 1999

Multa

Dr. Mall Olnes,

SHBMC, 4900 tasher Are 32. Registrer's Signeture

DLWES

30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print)

RES-000

Bellinue, UD 21224

8/18/99

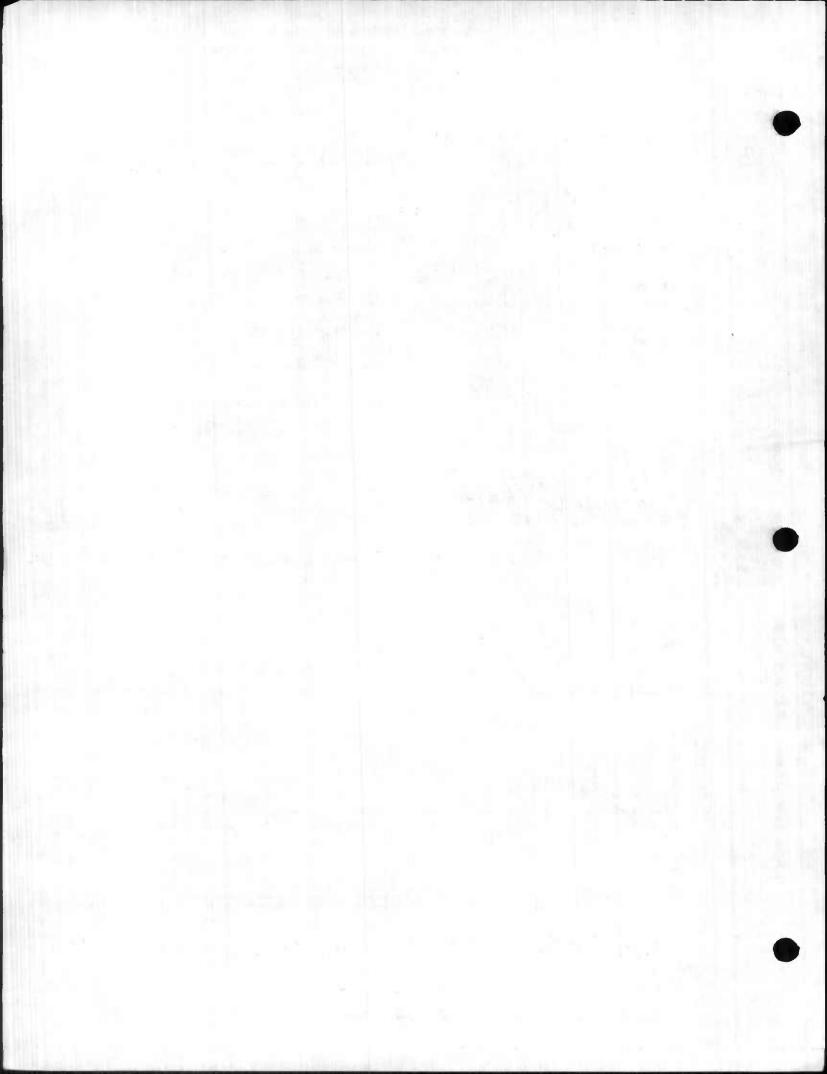
AUG LEIST Server A August

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

_	Decedent's Name (First, Middle, L.)	State of Marylai	Certific			2. Date of D	Reg. No.	9 8	3. Time of Death
Physician /Medical	Irma Worsha					Month Augus	Day	Year 99	8:10 PM
Examiner	4a Facility Neme (II not institution, gi	*			4b. City, Town, or				
	Villa St. Michae				Baltimo			/A	
Funeral Director		Sex 1□ M 2X F 88		ths Days		. (Month, D		9. Birthol Count Mary	ace (State or Fore iny) and
ž u	10e. State 10b. County	10c. C	ity, Town or Location	_				10	0d. Inside City Lim
the part	Maryland	N/A	Baltimo	ore					XX Yes 2
tems 23e or 23e-f shor oer must be notified at uneral Director	10e. Street and Number 4800 Seton Drive		10f	Zip Code 212	15		10g. Citizen of V USA	What Count	try?
Erami by F		12. Was Decedent Ever in U Armed Forces? 1 Tyes 2/1/No If Yes, Giva Year or Dates:	if Yes,	specify Cub	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or N to Rican, etc.)		e - America ck, White, a v: White	atc.
ygiene. er then 'natur 4, the Medical. Completed	15. Decedent's E (Specify only highest gr				pation during most of wo ad)	orking	16b. Kind of Bu		
	17. Father's Name (First, Middle, Las.	2)	Homemal	ker	18. Mother's Na	me (First. Middl	e, Maiden Suman	Home	
arkad off affic even To Be		H. Worsham			100	ia Pee		,	
and Ma is ment humes	19a. Informant's Neme/Relationship		19b. Mailing Add	ress (Street	t and Number or F			State, Zip	Code)
122	Villa St. Michae	1	4800 5	eton [Drive Ra	ltimore	Maryla	nd 21	215
of Ha Hem r oths	20e. Method of Disposition	20b. i	Place of Disposition cometery, crematory	Name of or other pla	Orive, B	Date	20c. Location -	City or To	wn, State
ant: If Its any or o	X Burial 2 Cremation 3 [4 Donation 3 Dother (Speci	(y) State	. Mary's	Ceme	tery	8/24/99	Baltimo	re, M	Maryland
Import any inj	21. Signature of Funeral Service Lice	2 X/a A/	Davie	11.	ess of Facility	z Funer	al Home,	Inc.	21211
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the dea	th. Do not enter the	mode of dyi	ng, auch as cardia	Baltimo or respiratory	re, Mary	land	Approximate Intarval Between
Medical laminer	Immediate Cause (Final disease or condition resulting In death)	a. END STA	GE ALZHZ for as a consequence		R DEMK	NTIA		6	OMONTI
physicien and s the bunel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	or as a consequence					1	
d by the attending petached for use as Physician/Me		d						1	
the at ned for	Part II. Other significant conditions	contributing to death but not res	sulting in the underlyi	ng cause gi	ven in Part I.	23b. Dic	f tobacco una co	ntribute to	the cause of dec
b ed						10	Yaa 2□No	3 Prob	ebly 4 downkr
page 2 should I						24a. Wa per	s an autopsy formed?	ava	ra autopsy findin- allable prior to apletion of cause death?
Page Com						1□	Yas 2 No	10	Yes 2 No
certificate rector, pag	25. Was case referred to medical examiner?	Hospital:		Or	har at	ath (Check only			
ther this of uneral din on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Let Nursing	1	how Injury occur		')
a after deam. I Director: After t led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	On Diese of leium. As h	nome, farm, street, facility)		Yes 2□No		(Street and Numb own, State)	per or Rura.	l Route Number,
Medical Certific	29a. Certifler 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the ti	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and ma , date and place,	anner as st and due to	ated. the cause(s)
Me Me	29b. Signeture end title of certifier	A state of state of		29c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)
s F 6	Nobrahal !	Sierco		440	5931		Augus		
	30. Name and address of purson who	completed cause of death (ites	m 23a) (Type, Print) H I PIE)	KE	7220	Park			Ave Ba
State Registrar	31. Date tiled (Month, Day, Year) AUG 2 4 1999	32. Registrar's Sign	9. Spor	w			3		

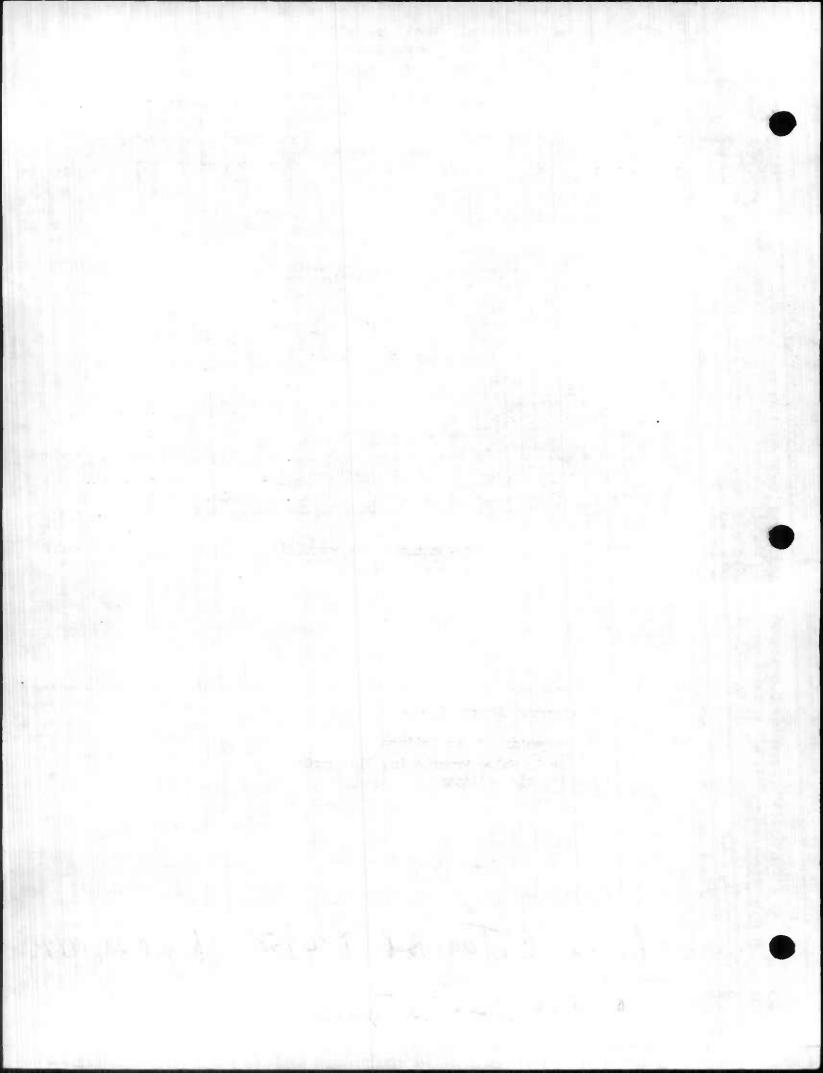
Division of Vital Records, P.O. Box 68760,

works



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Decedent's Name (First	et Middle 1 -	net)		C	ertifica	te of I	Death		2. Date of Dea	Reg. No.	C C 1	Time of Deeth
n al		Char	les Jo	hn Za	ledon				Month August	Day 20, 19	Year 199	3:45am
4a Facility Name (If not it						1			ation of Death	4c. County	of Death	
VA MARYLANI 5. Social Security Number			SYSTEM . Age (In yrs.	for an in last of a	If Linds	er 1 Year		HOW T	RICCI 8. Date of Birth	Ba.	ltimore	
189-03-7923	1	1 N 2 □ F	80	Yrs.	Months		Hours	Min.	Augus La	23, 191	8 Country) Penn	(State or Foreign
Usual Residence of Dece 10a. Stete 10b.	County		10c. Cit	y, Town or	Location						10d.	Inside City Limits
Maryland 10e. Street and Number	Bal	timore					Dur	nda1k				1 ☐ Yes 2 ☒ No
10e. Street and Number 2722 Plain:	e i o l d	Dood			10f. Z	ip Code	2122	22		10g. Citizen of N	What Country?	
11. Merital Status	Tield	12. Was Deced	lent Ever in U	S. 11	B. Was Dec	edent of H			city Yes or No-	14. Rac	e - American I	ndian.
1 Never Married 3		Armed Ford 1-2 Yes If Yes, Give Yeer or De	ces? 2 □ No tanate t		If Yes, sp 1 ☐ Yes	ecify Cuba	Specify:	i, Puerto P	lican, etc.)	Specify Specify	ck, White, etc. y: Whit	e
15. E	Decedent's E	ducation		16a. Dec	edent's Us	ual Occup	ation	a and considering		16b. Kind of B	usiness/Indust	у
(Specify on Elementery/Secondery		ade completed) College (1-	4or 5+)	life	DO NOT	ork done i use retired	Beth!	lehem	Steel	Steel		
10 Years	` '			P	olice	Depa	artmen	nt		Indust	ry	
17. Fether's Neme (First,	Middle, Last,)					18. Mothe			Maiden Sumen	ne)	
John Zale	donis							Celi	a	Not	Known	
19e. Informant's Neme/R										r. City or Town. lk, Mar	1214	
20e. Method of Disposition			20b. F	Plece of Dis	position (Na	ame of		1	Date	20c. Location -		
to Burial 2 ☐ Cre 4 ☐ Donetion 5 ☐ C			tete		rematory or			8/124	/1999	Rose	dale M	laryland
21. Signature of uneral			Ga									
Loca	, 5	112)	-						Dundal:		
Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to Immediate cause. Enter Underlying	Jan Caponiy		cute B	acter		ndoca				H	On	proximate arrval Between set and Death
Sequentially list condition if any, leeding to immedia	ns, ate	b. ———	Due to (d	r es a cons	equence of):					1 1	West .
Sequentially list condition if any, leeding to Immedia cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest	1	c	Due to (o	r es a cons	equence of	i:					i 	P ha
		d										
Pert II. Other significant	conditions o	contributing to dea	th but not res	ulting in the	underlying	cause giv	en in Part I			Walter Commission		cause of death
	Con	onary He	art Di	sease					10'	Yes 2 No	3 ☐ Probabl	y 4 ☐ Unknow
		gestive								en autopsy med?	aveilat	autopsy findings ble prior to ation of cause
		tic Valv			s, Ol	d Str	roke		400	• • • • • • • • • • • • • • • • • • •		
25. Was case referred to		betis Me	llitus				00 01	10 1	101	Λ	1016	es 2 No
examiner?	medical	Hospitel:	patient 2	ED/Output	ient 3 C	Oth Oth	05		(Check only o	<i>ne)</i> lence 6 □Oth	nor (Chaoibi)	
27. Menner of Death		28a. Dete of		28b. Time		28c. Injur	4 🗆 IAA	-		now injury occur		
2 Accident	Pending investigetion Could not be	e 28e. Plece o	of Injury - At he	Injun	М	10	k? Yes 2□		8f. Location (5	Street and Numi	ber or Rural Ro	oute Number,
	determined	Duliding	g, etc. (Specif	<i>y)</i>					City or Tou	m, Siere)		
4 ☐ Homicide	determined	nysician: To the base and menne	is of examine	wledge, de tion end/or	ath occurred	d et the tin	ne, date an pinion, dea	id place, a	nd due to the o	cause(s) and made end place,	anner as stated and due to the	d. cause(s)
4 Homicide 29e. Certifier (Check only 2 hone) 29b. Signeture and title or	Certifying Ph	nysician: To the base and menne	is of examine or steted.	tion end/or	investigatio	d et the tin n, in my o	pinion, dea	ad place, and the occurre	nd due to the d	cause(s) and midate end place,	and due to the	cause(s)
4 Homicide 29e. Certifier 1 (Check only 2 A nee)	Certifying Phedical Exam	nysician: To the base and menne	is of examine or steted.	tion end/or 23a) (Typ	e, Print)	on, in my o	pinion, dea	58	d at the time,	date end place,	and due to the	cause(s)



DHMH 16 Ray 6/95

State Registrar

200 memorial

32. Registrer's Signeture

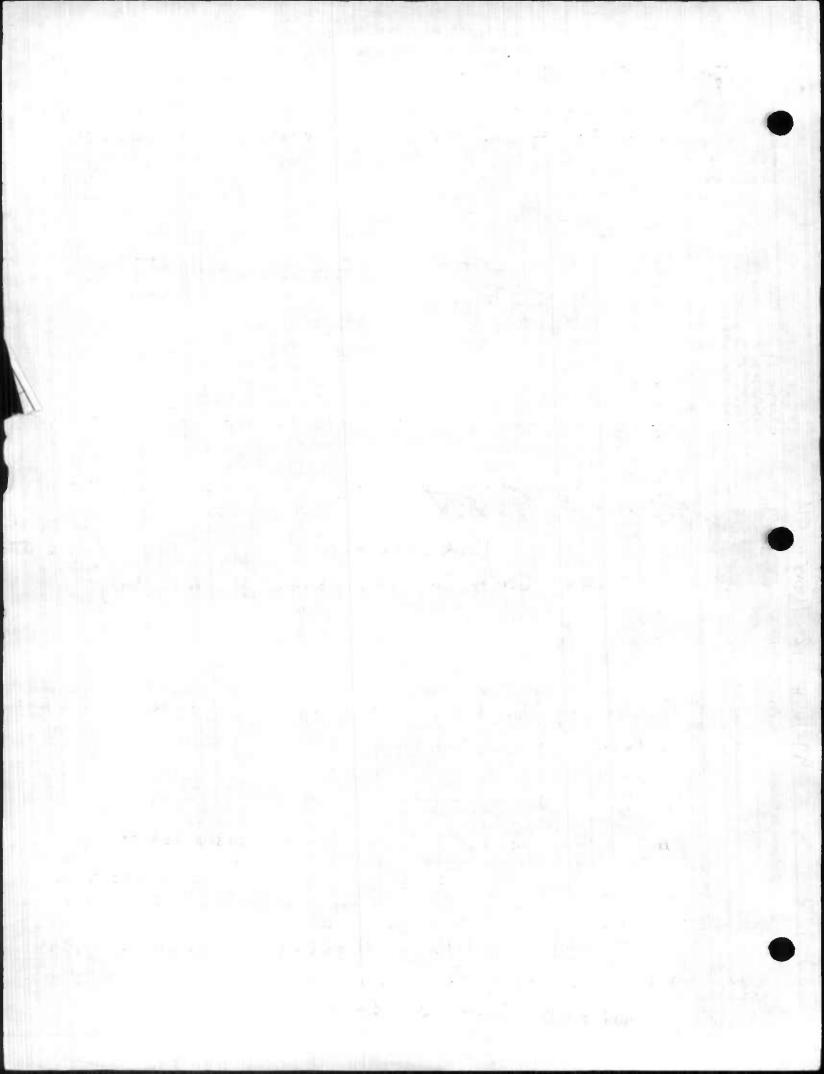
Hue, Wastminster

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BOAITEY

31. Dete filed (Month, Dey, Year)

AUG 2 5 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

HAZ	EL BELL				State of	Marylar	nd / Depa <i>Cei</i>			Death		ental H	Reg. No	00	21	5622
	Physician /Medical		Decedent's Name (First, Midd Hazel	le, Last)			Bell					2. Dete of Month AUG .	20		Year 99	3. Time of Death 10:58 AM
	Examiner	4.4	Facility Name (If not institution 11 WEST 20TH S		ET APT.	#2-R					IMORE			: County	of Death	
	Funeral Director		Social Security Number 216-42-5728 sual Residence of Decedent	6. Sex	M 2₹ F	7. Age (In yrs. 66	last birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Data of I (Month,)6 C		33	9. Birthple Count	ace (Steta or Foreign ry)
	ahow star	10	Da. State 10b. County				ny. Town or Lo								10	od. Inside City Limits
	or 28a-f	10	MD NA De. Street and Number			B	artriid	10f. Zip	Code				10g. Ci	itizen of V	Vhat Count	
020	filed within 72 hours after death with the Maryland Hydione. Hydione. Internation 23s or 28s-(show int, the Medical Establish must be notified a Completed by Euraval Director.	1	I West 20th I. Merital Status 1 Nevar Married 2 Mai 3 Widowed 4 Divorced	ried	2. Was Decer Armed For 1 Yes If Yes, Give Year or Da	dent Evar in U ces? XXNo	J,S. 13.	Was Dece	cify Cub	L8 dispanic Or an, Mexica Specify	igin? (Spec n, Puarto R	cify Yes or lican, atc.)	No-		e - Amarica k, White, e	itc.
21215-0020	within 72 hours at iene. then "natural", or or winder Earth		15. Deceder (Specify only highs Elementary/Secondary (0-12)	nt'a Educe	etion		16a. Deced (Give life.	dent's Usu kind of wo DO NOT u	al Occup ork done se retire	pation during mos d)	t of workin	g	16b. F	Cind of Bu	usiness/Indi	
and 2	s 1 and 2 should be filed within 72 hc theath and Mental Appiene. other traumatic avant, the Medical To Re Completed	3	8th grade 7. Father's Name (First, Middle, Richard Cor		na		Pro	oces	sor			(First, Midd	lle, Meider			or Lab
Σ	1 and 2 should be Health and Mental am 27 is marked o other traumatic av	1	9a. Intorment's Neme/Relation Linda Berry-	ship (Typ			19b. Mailir 3414			end Numb	er or Rural		nber, City		Stete, Zip	Code)
0	8 = 5	20	Da. Method of Disposition Warriel 2 Cremation 4 Donation 5 Other (5)	3 □Ra	_	teta	Plece of Dispo cemetery, cree	netory or	me of other ple	ce)		Dete	20c. L	ocation -	City or Tov	wn, State
Balt	Department Proportion or Important any Injury attics.	1	1. Signatura of uneral Service	20	8An	ces)	Ma 4	arch	F/I	ss of Facili H Wes	st Ave,	Balt	imo	re M	ıd 2	1215
d.	Physician /Medical Examiner	tr	Sa. Part1. Enter the diseesa, o shock, or heart tailure. Lis nmediete Cause (Final isease or condition esulting in death)	a.	e ceuse on ea	tensive	e Arter	riosc	lero					Disea		Approximate Interval Between Onset and Death
oʻ	physician and s the bunal-transit	Sit o	equentially list conditions, any, leading to immediate suse. Enter Underlying ause (Disease or injury	5 b.		Due to (or as a consec	luence ot)	•							
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ecords	aw requires 18 been sign 2 should be											pe	es an auto erformed?		ava	re autopsy findings illable prior to npletion of cause death?
= 5	certificate ha		5. Was case reterred to medica	1						26 Piec	e of Deeth	(Check on		No	1	Yes 2□ No
of V	5 D		axaminer? XX Yea 2 No	Ho	spitel:	patient 2	ER/Outpatier	nt 3 D	OA Oth	oor				6 Oth	er (Specify)
vision	After fune		7. Mannèr ot Death XXNatural 5 □ Pendii 2 □ Accident invest 3 □ Suicide 6 □ Could 4 □ Homicide	not be	28a. Date of (Month) 28e. Place of building		28b. Time of Injury	М		yat rk? Yes 2⊡	No			and Numb		l Route Number,
	Funer Funer Hely fill		9a. Certifier (Check only one) 1 Certifying Medical	ng Physic Examine	cian: To the b	est ot my kno	owledge, death	occurred	at the tin	me, date ar	nd place, a	nd due to to	he cause(:	s) and ma	inner as sto	ated. ' the cause(s)
	within 2 comple		9b. Signatura and title of certifie	1	end manne	or stated.	N	29		e number	r				d (Month, L	
K	0)	30). Neme and address of person	who.com		1	m 23a) (Type, 11 Penr	-				Mar	AUG		20, 19	777
	State	31	Dete tiled (Month) Day, Year,	1		gistrar's Sign					ALIK/L C	.,	. J.J.CH.R	ىلىتە مى	OVI	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 12.27 Am **Physician** Month August CHARLOTTE 1999 6 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Northwes 5. Social Security Number Yed Bahmore Under 24 Hrs. 8. Dete of Month enter saltimore If Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) Months Days Min. 137-28-8995 Usual Residence of Decedent 1 M 201 Hours South Carolina Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If Ilem 27 Is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, in Medical Exprinter mult be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Yes 2□No Directo More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 02 dra Funerai an 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black. White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₺ No Specify: þ 3 ₩idowed 4 Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurse Ld 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be P)avo Plat HOUSION 19a. Informent's Name/Relationship (Type, Print)

Daug Her In-lay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Barnwell 20b. Place of Disposition (Name of cametery, criemetery or other place) Ramallstown Md. 212
Pate 20c. Location - City or Town, State Mrs 21207 20e. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removel from State □ Denation 5 □ Other (Specify) Jultimore. Signature of Funeral Service Licensi LUP Part 1. Enter the risease, or of mplication, that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, clock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical fmmediete Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last attending physician Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 1 ☐ Yes 2 ☐ No Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ₺ No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, is 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes a No 1 Inpatient 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, offica building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated. Medical 29a. Certifier

State Registrar

31. Date tiled (Month, Day, Year) AUG 2 5 1999

29b. Signature and title of cartifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NU

29c. License number

15044

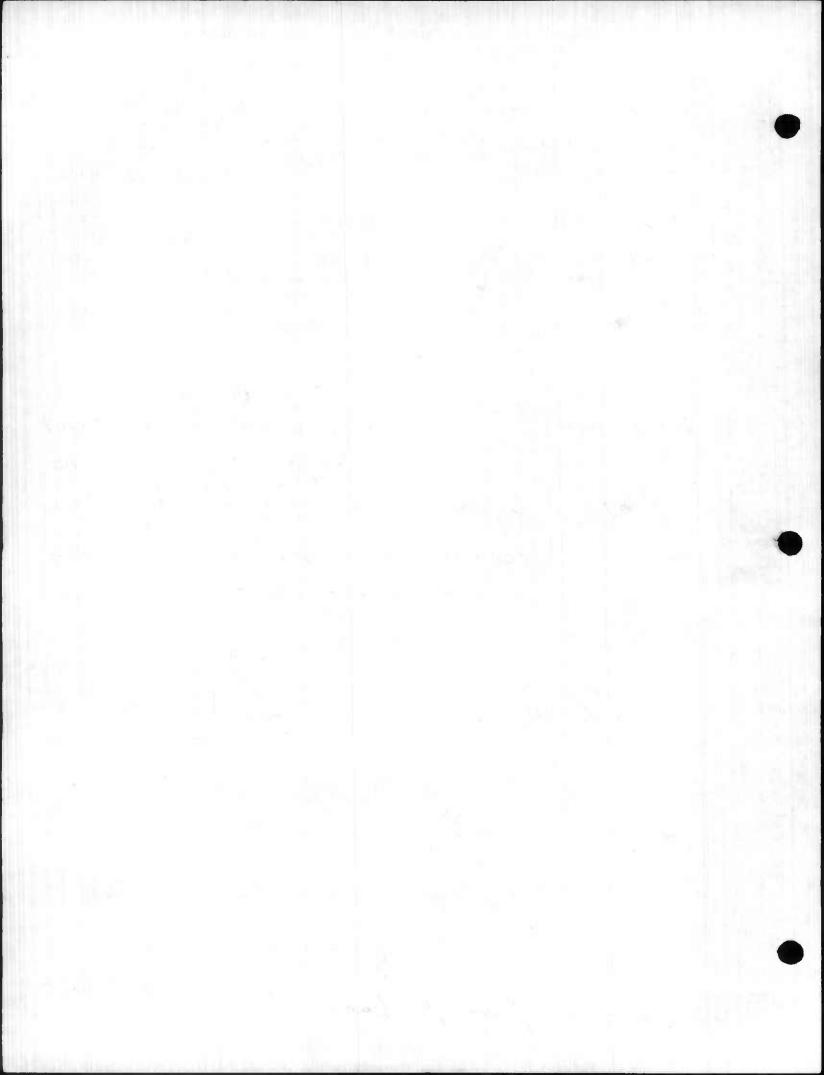
2717 Hammand FerryRel

29d. Date signed (Month, Dey, Year)

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

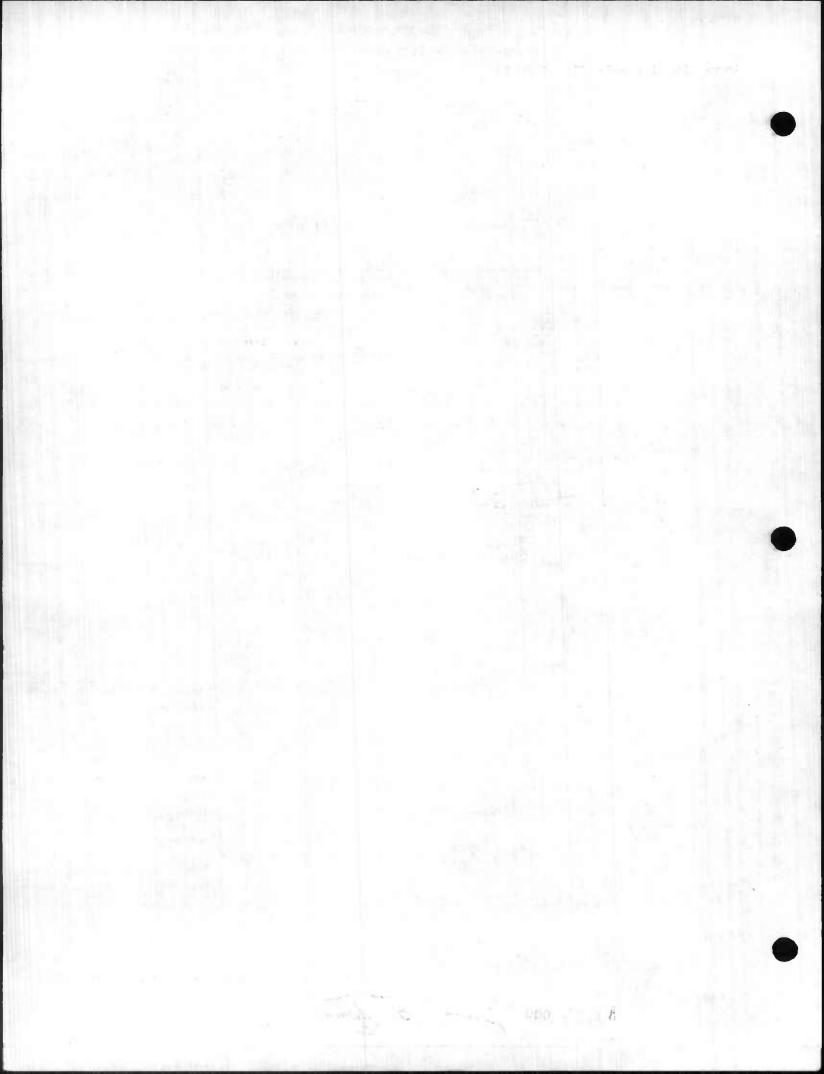
Maryland 21215-0020



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

ASP Amende	ed Item#16a perFH G774 8/25	State of Maryland / D	epartment of Hea Certificate of De		Hygiene 9	26624
Physicia /Medica Examine	DAVON	JEROME reet end number)	BLUE	2. Date Mon AUG	UST 18 19	Year 3. Time of Death 399 3:01 A of Death
Funeral Director	BAYVIEW HOSPITAL 5. Social Security Number 219-82-8813 Usual Residence of Decedent	T. Age (In yrs. lest birth	hdey) If Under 1 Yeer If	ALTIMORE Under 24 Hrs. 8. Detections Min. (Mon	of Birth th, Day, Year) 12,1974	9. Birthplace (State or Foreign Country) MARYLAND
h the Maryland r 28a-f show Lnotffled at	10a. State 10b. County MARYLAND N/	10c. City, Town	Or Location BALTIM 101. Zip Code	ORE CI	7 10g. Citizen of V	10d. Inside City Limits 1 Yes 2 □ No
020 urs after death with or last to thems 23a o Examiner must be	526 ORCHA 11. Meritel Stetus 12 Never Merried 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	13. Was Decedent of Hispa If Yes, specify Cuban, I	2 / 2 0 / Inic Origin? (Specify Yes Mexican, Puerto Rican, et	U 3	e - American Indien, k, White, etc.
	15. Decedent's Educ (Specify only highest grade Elamentery/Secondary (0-12) 17. Father's Neme (First, Middle, Last)	ation completed) 16a. College (1-4or 5+)	LABOI	n ng most of working Never Worked L. Mother's Name (First, M	16b. Kind of Bu	IA
Maryland	17. Father's Neme (First, Middle, Last) WILBERT 19e. Informent's Neme/Reletionship (Typ BERTHA, TONES	e, Print) 19b.	Meiling Address (Street end	BERTHA Number or Rural Route	Number, City or Town,	STACKER
Baltimore Baltimore Department of H Copartment	23a. PM1. Enter the disease, or complic shock, or heert feilure. List only one limediate Cause (Finel disease or condition resulting in deeth)	movel from State Cameter,	22. Neme end Address of SEPH of enter the mode of dying, s	FRY 8-25- Fedity H. BROWN UL TON AVE	JR. FUNE.	RAL HOME THAPE HD. 2121' Approximate Interval Between Onset and Deeth
8760	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting In death) Last	Due to (or es e c				
Dy the	Pert II. Other significant conditions cont	ibuting to death but not resulting in	the underlying cause given i	n Pert I. 23t		atribute to the cause of death? 3 Probably 4 Unknow
	Ag passed upon the company of the co			24a	. Wes an autopsy performed?	24b. Were eutopsy findings svaileble prior to completion of cause of death?
Vital	25. Wes case reterred to medicat examiner?	spitel:	Other:	3. Place of Deeth (Check		1 ⊠Yes 2□ No
DIVISION OF or Attending Physical death. Director: After this in by the funeral of		28a. Dete of Injury 28b. T	ime of Jack Mark?	281. Loca City	cribe how injury occurring the following occurring the following occurring to the following occurring	ed
To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge, or: On the basis of exeminetion end and menner steted.	deeth occurred et the time,	date and piece, and due	to the cause(s) end me	nner es stated.
To the vithing To the comp	29b. Signature and title of certifier	1 Chuten	29c. License no			18,1999
	30. Name and eddress of person who some Dennis J. C.	hute w	Type, Print) 111 Penn	Street, Bal	timore, Ma	ryland 21201

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#19b perFH G774 8/25/99 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day Year KEBECCA 8:30 AM 19, 1999 4c. County of Death AUGUST 4s Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death NORTH AMITY STREET BALTIHORE If Under 1 Yeer Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7/Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) 8 Yrs. Months 1 M 2 F 244-46-7012 EB. 27, 1921 NORTH CAROLINA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MARYLAND ALTIMORE 10e. Street and Number 10g. Citizen of What Country? 20 NORTH 12. Wes Decedent Ever in U.S. Armed Forces? 2122 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THGRADE HOMEMAKER OWN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BRUCE EDWARDS GRIM ASTER 19a. Informant's Name/Relationship (Type, Print) 19b. Meilling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENO (GRANDSON) 40 90802 585 WALNUT AVENUE DAVIS 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 1 Burlel 2 ☐ Cremation 3 ☐ Removel from State ZION CEMETERY 8-26-99 4 Donation 6 Other (Specify) LANS POWNE, HAR/LAND 22. Name end Address of Facility 21. Signature of Funeral Service Linear 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. BROWN JR. FUNERAL Home MAZIZI Approximate Interval Between Onset and Death Immediate Cause (Final Athleoschelotic Caediovascular Disease diseese or condition resulting in death) Due to (or as e consequence of): Afectentian (Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence or): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Breast Gecinoma 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work?

Physician /Medical Examiner

Department of Health er Important: If fem 27 is any injury or other treu

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

ò items 23a

naturel', or

Pages 1 and 2 should be filed within 1ent of Health end Mentel Hygiene. nt: if item 27 le marked other than 1

72 hours after

Baltimore, Maryland 21215-0020

Director

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Completed

Be

Physician/Medical Examiner þ Completed Be 2

physician and s the burial-trans this funeral Certification: After or Attending r death. To the Hospital or Atten-within 24 hours after deat To the Funeral Director: filled in by

Records, of Vital Division

> State Registrar

edical

31. Date filed (Month, Dey, Year) AUG 25 1999

Jyoten

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending Investigation

6 Could not be determined

29b. Signature and title of certifier 30. Name and address of person y no completed cause of death (Item 23a) (Type, Print) 821 tarikh MD

29c. License number 32158

t ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

N. Eutaw Street, Suite 407, Baltimore, MD21201

32-Registrer's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

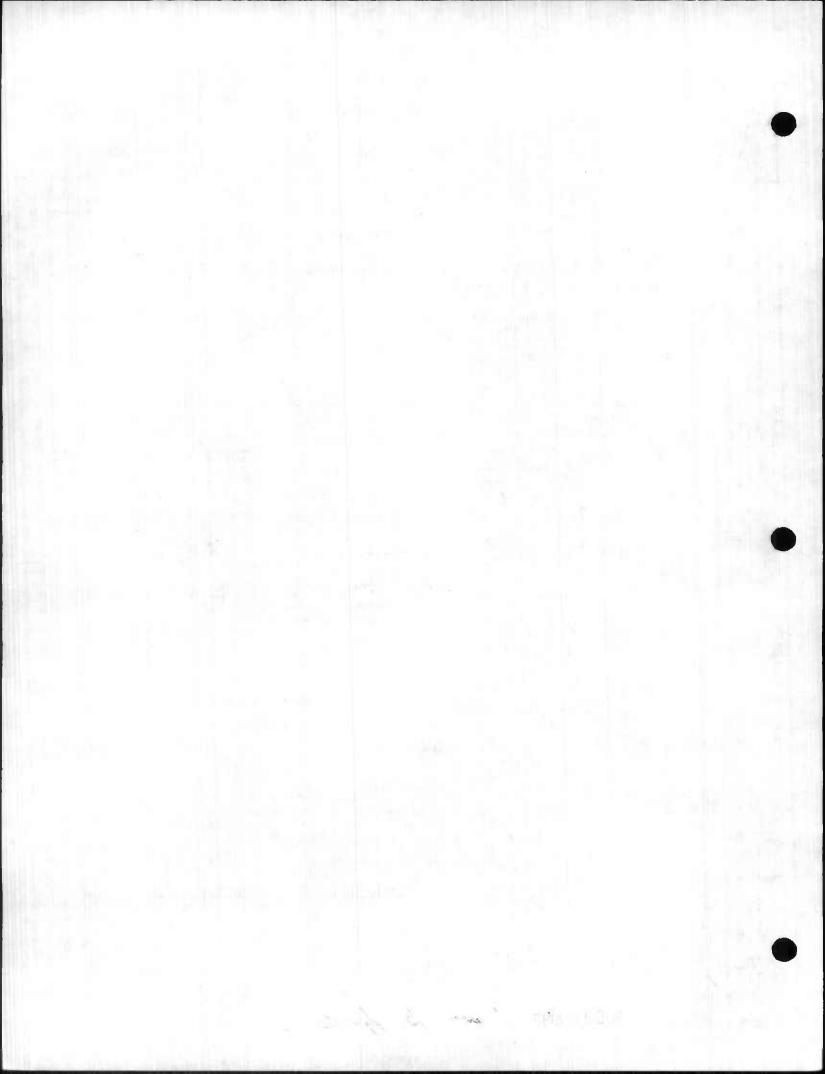
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State of Maryland / Department of Health and Mental Hygiene 99 26626

				C	ertificat	e of i	Death		R	eg. No.		302.0
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xaminer	4a Facility Name (If not institution, LEVINDALE HEBI	REW HOME					BALT	IMORE		4c. County	1	N/A
neral ector	083-42-4619	6. Sex 1 □ M 2 🕱 F	7. Age (In yrs	78 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, SEPT - 8	Year) 1,1920		ce (Stete or Foreign y) IA, AUSTR
notthedat	Usual Residence of Decedent 10a. Stete 10b. County MD BALTIM	חסר		ity, Town or							100	Inside City Limits 1 ☐ Yes 2 No
be notified Director	10e. Street and Number	JKE .	FI	KESATI	101. Ziç	Code			1	0g. Citizen of	What Country	y?
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dical	15. Decedent's (Specify only highest			16a. Dec	cedent's Usu ve kind of wo	al Occup	ation during mos	t of worki	ing	16b. Kind of B	usiness/Indu	stry
Completed	Elementery/Secondary (0-12)	College (1	-4or 5+)	life	MAKER	se retired	a)			OWN H		
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by Phy	TRANSECTION OF	SPINAL	CORD	Cl-	-C2				1 🗆 Y	es 2□ No	3 ☐ Proba	bly 灯 Unknow
Completed b									24a. Wes a perform		avail	e autopsy findings lable prior to pletion of cause eath?
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To Be	25. Was case referred to medical axeminer?	Hospitel:				Oth		e of Deeth	(Check only on	e)		
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completely filled in by the funer Medical Certification		Physician: To the xaminer: On the ba	sls of examin									
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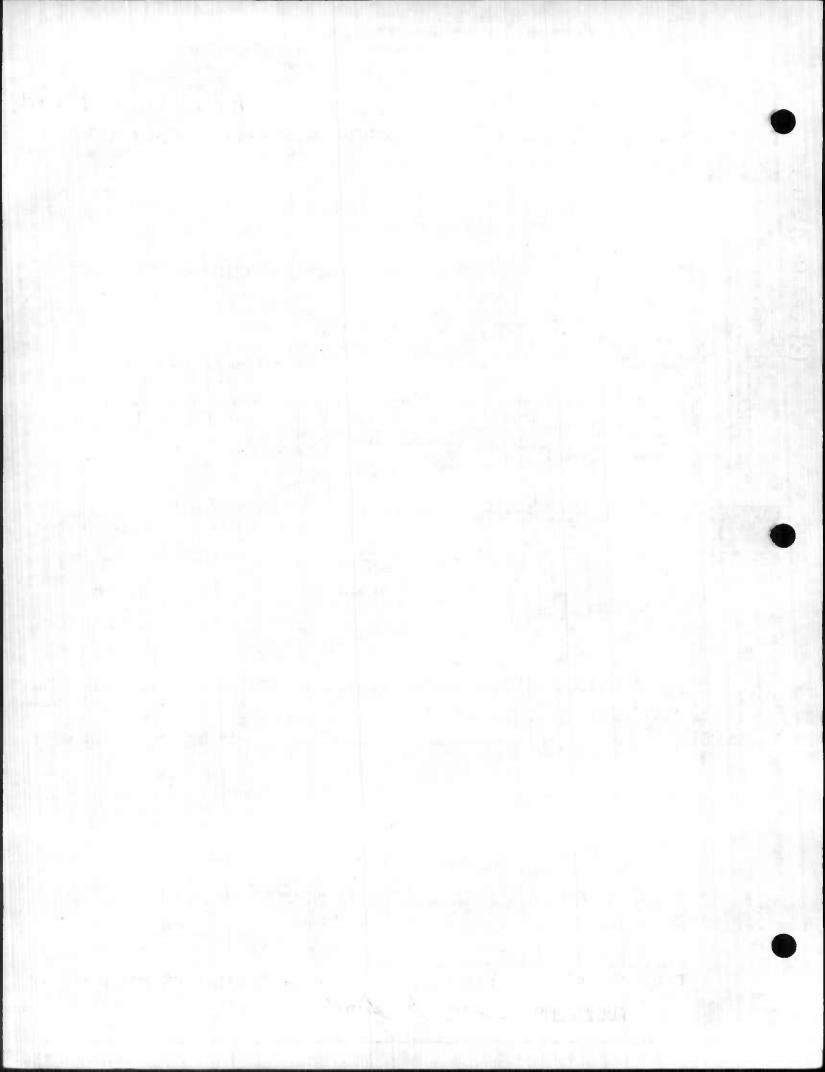
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100	e. Street and Number 1127 Ches	ster Ro	oad		10f.	Zip Code	2122	0		10g. Citi	izen of V	What Coun	try?
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yes James McDonald Baker Aug. 21 1999 3:30 PM 4a Facility Neme (II not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Deta of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours Months 1₽M 2□ F Yrs. 246-60-8516 Sept. 12, 1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 131 Timberbrook Lane #203 20878 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Nevar Married 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondery (0-12) College (1-4or 5+) English Teacher School System 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Joseph Mack Baker Ann Carolyn (Dove) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Rosalie A. Baker (Wife) 131 Timberbrook Lane, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Aug. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt./Wash. Crematory Laurel, MD 24, 1999 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, 21045 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Itour disease or condition resulting in death) MASSIVE PONTINE Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last BASILAR Due to (or as a con Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

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"natural", or items 23a

Hygiene.

permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: if them 27 is mentaed other tha. any injury or other tree

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

P

Completed

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10

burial-transit and physician s s the burial Box 68760. 88 980 Division of Vital Records, P.O. signed by t has

Examiner Physician/Medical à Completed Be Certification: To this ospital or Attending hours after death. Director: /

in 24 hour.
The Funeral Dire.
The filled in by To the Hospital of within 24 hours a To the Funeral D completely

DHMH 16 Rev 6/95

State Registrar

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27. Menner of Death

Netural

2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cartifier

5 Pending

invastigetion

6 Could not be

28c. Injury at Work?

29c. License number

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLY

28a. Dete of Injury (Month, Day Year)

SILVER 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

28b. Time of

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

AUG 25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 955PW 20 /Medical 4e. Fecllity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** m 2004 9 Itimore Timore 8. Dete of Birth (Month, Dey If Under 1 Yeer If Under 24 Hrs 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2×F Deys Yrs. Director Usual Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryle must of Heelth and Mental Hygiehe.
The filem 21 is marked duther than "natural", or items 23a or 28a-f show it from 27 is marked duther than "natural", or other traumatic avent, the Mages II Examine must be incritised.

Iny or other traumatic avent, the Mages II Examine must be incritised. Maryland 1 Ses 2 No Director imore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus Rece - American Indien, Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: Negro 3 ₩Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme), Be 19a. informent's Name/Reletionship (Type, Print) (SOM 19b. Mailing Address (Strg ington ohnn 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Joseph W. North Ave. the charge, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart to ure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest P.O. Box 68760, Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy lindings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? this certificate Division of Vital 25. Was case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 ☐ ER/Outpetient 3 ☐ DOA apatient within 24 hours after death.

To the Funeral Director: After this completely filled in by tha funeral of 27. Menner of Deet 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation Neturel Accident 1 Yes 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) Pieca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner as steled.

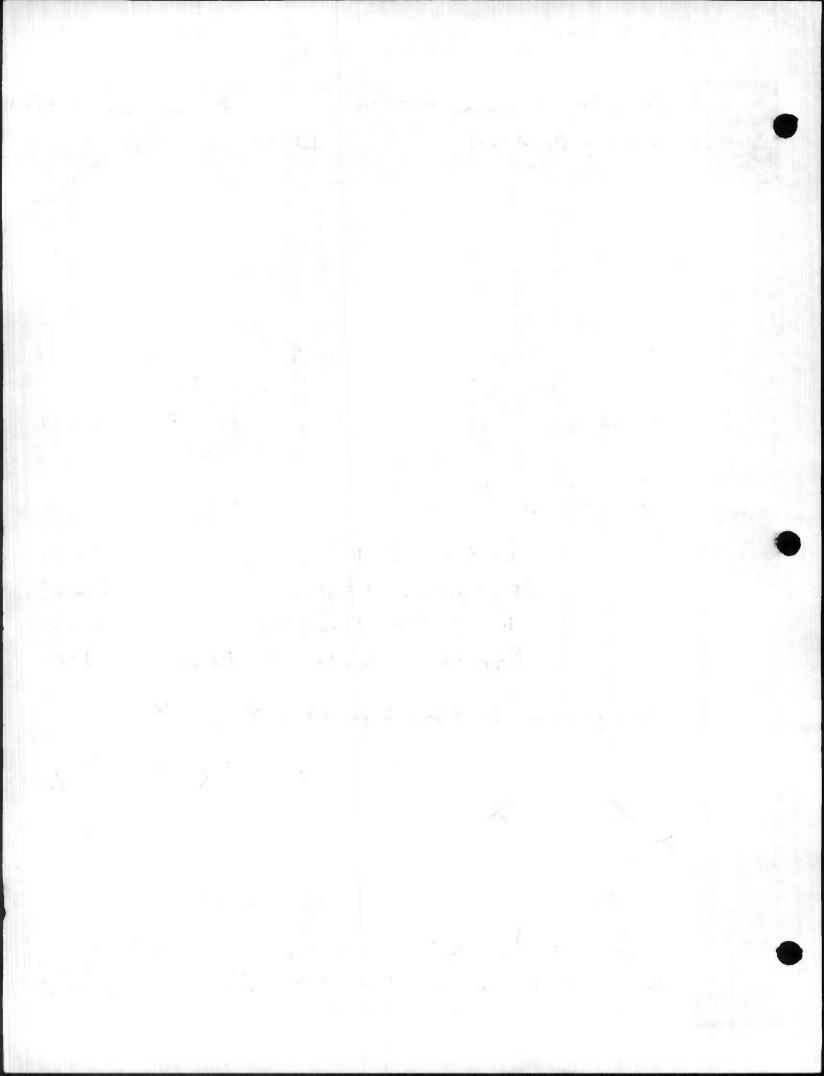
Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner steled. 29e. Certifier To the 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 29c. License number 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) t. 0. -1 Plice 30 ~c 4 2 6 0

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) AUG 2 5 1999

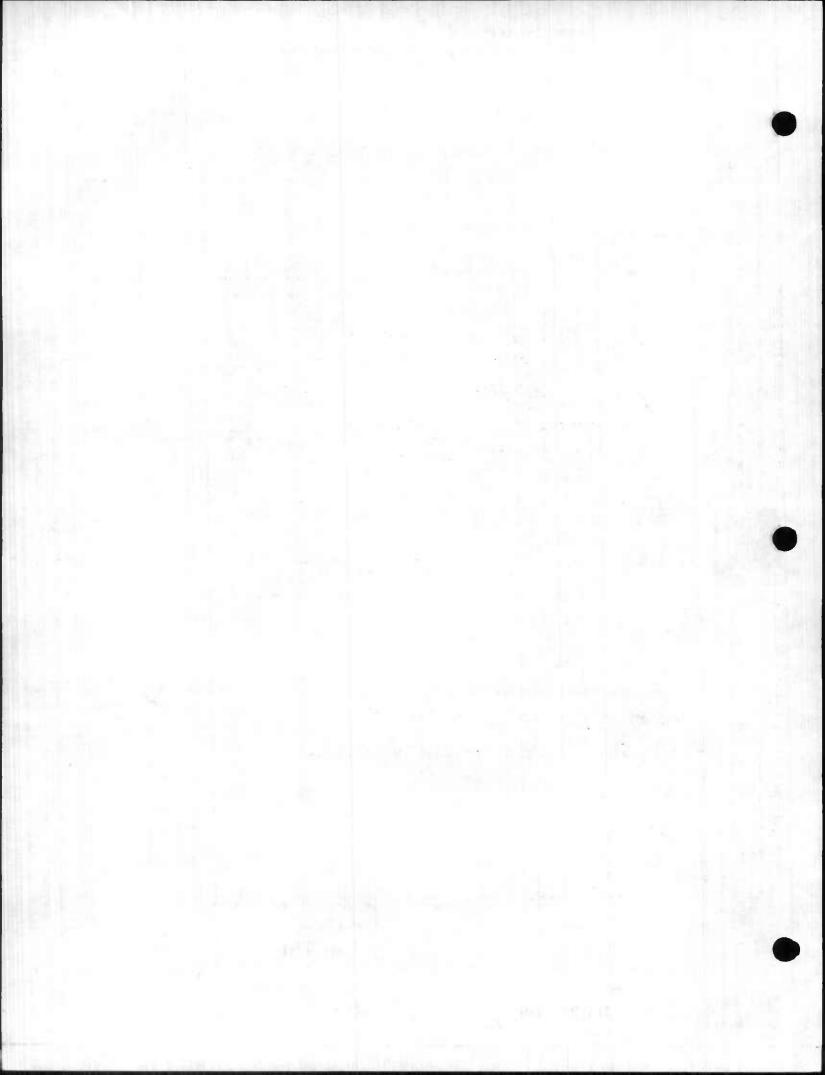
Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certif	icate of	Death		Reg. No.	9 26	630	
	na (First, Middle, Las	st)					2. Data of De Month	ath Day	Year 3.	Fima of Death	
Physician James		J.		Cuf	fie		Augus			2:30am	
	If not institution, give	e street and number)				4b. City, Town, or	Location of Deat	4c. County	of Death		
Lorier	Frankf	ord Nurs	ing +	Reha	b. Ct	n. Balt:	imore		NA		
5. Social Security I	Number 6. S	ex 7. Ag	e (In yrs. last	birthday) H	Under 1 Yaa onths Days	r If Undar 24 Hrs	8. Data of Bir	th v, Year)	9. Birthplaca	Stata or Foreign	
or 246-07-	-2090 4	ØM 2□F	77	Yrs.		5 21					
Usuel Residence of 10a, State	10b. County		10c. City. T	own or Locati	00				10d In	side City Limits	
10 Acc -2250	NA			Ltimor						Yas 2 No	
10e. Street and Nu					Of. Zip Code		1	10g. Citizen of V	What Country?		
=	rankford	Avenue			2120	16		USA	Will Country?		
11. Marital Status	Lamitola	12. Was Decedent	Ever in IIS	13 Was			nacity Yas or No		e - Amarican Inc	lian	
1 Never Mar	ied 2□ Married	Armed Forces?		If Ya	s, specify Cu	Hispanic Origin? (S ban, Maxican, Puar	to Rican, atc.)	Blac	ck, Whita, atc.		
3 Widowed	-	1√E Yas 2 ☐ If Yas, Giva Year or Datas:		10	Yas XXN	Specify:		Specify	Black	2	
3	15. Decedent's Ed	lucation	1	6a. Decedent	's Usual Occu	pation		16b. Kind of Bu	usiness/Industry		
© Elementery/Sec	cify only highest gra	de completed) College (1-4or !		(Give kind lifa. DO	l of work done NOT use retir	e during most of wo	rking				
(Special Special Speci		2vrs.	74)	Graph	ic Ar	ts		Dept.	of Arr	nv	
17. Father's Name	(First, Middle, Last)						ma (First, Middla,	-			
2 Edwar	đ	Cuffie	2			Stell	a	Cuffi	le		
	ame/Reletionship (7	Type, Print)		19b. Meiling A	ddrass (Stree	et and Number or R	ural Routa Numb	er, City or Town,	Stata, Zip Code)	
Ronald	Cuffi	e	1	LO17 L	och R	aven Bl	vd. Ba	ltimore	e, MD.	21218	
20a. Mathod of Dis	position		20b. Place	e of Dispositio	n (Nama of		Data	20c. Location -			
	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from Stata				'1 Cem.	08-26	-99 Ba	altimo	ce, MD	
	unaral Service Licen			22. Na	ama and Addrass of Facility Baltimore, Maryland 21202						
DR ON	23a. Part1. Enter the disease, or confusion that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or hard failura. List only one cause on each line.										
23a, Part1, Entar											
shock, or hae	rt failura. List only	one cause on eech li	ne.				,		Inter	oximate val Between et and Death	
Immediata Causa	(Final	AD	IANIC	M	MT	the MKM	7			105	
diseasa or condition rasulting in death)	an .	a. 1/4"	Due to (or as a consequence of):						1	trs	
ě			Due to (or as	a consequen	ca orj.				I i		
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Cause (Disease or that initiated evant	lnjury	C	Dua to (or as	a consequen	ca of):						
	Last			,					i		
2		d							1		
Part II. Other signif	icant conditions or	ontributing to death b	ut not resultin	g in the under	tying causa o	iven in Part I.	23b. Dld	tobacco use cor	ntribute to the	cause of death?	
of Chair					Co-		10	Yes 2 No	3 Probably	4 Unknown	
\$ CACAR	114 1090	CURITUS	ance	ns :	अहा है। इस	145					
B 0 0 0 0 0 0	v	c === 0		1-11	Arms		24a. Was	an autopsy ormed?	available	topsy findings prior to	
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1 25. Was casa rafai		Hospital:	nt 2∏ER	/Outpatient :	BI DOA O	ther:	loma 5□Rasi		er (Specify)		
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axaminar?	ħ	(Month, Da	y Year)	Injury		ork?]Yas 2 ☐ No					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** ANITA JOYCE CUMMINS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner osedale Franklin Square 5. Social Security Number 6. Se HOSP. try Cente If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 213-52-0699 1□ M 25 F 63 Months Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. Baltimore

8. Date of Birth (Month, Day, Year) March22, 1936 9. Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits Middle River 1 ☐ Yes 2 ☐ No

4c. County of Death

10g. Citizen of What Country?

USA

14. Race - American Indian.

Iti more

2. Date of Death

Maust

Month

2215 Firethorn Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)

10e. Street and Numbe

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

College (1-4or 5+)

Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname)

Irene Guthrie

Ethridge G. Dixon 19a. Informant's Name/Relationship (Type, Print) Blair E. Cummins/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Firethorn Road Baltimore Md. 21220

21220

20a. Method of Disposition 13 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 8/25/99

10f. Zip Code

20c. Location - City or Town, State Baltimore Md.

21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Connelly Funeral Home of Essex

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset end Death reeks

lea

3. Tima of Death

: 29am

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part	1.	

23b. Did tobacco use contribute to the cause of death?

bstructive Pulmonary Diseases

Yes 2 No 3 Probably 4 Unknown

Peripheral

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

) Sease 25. Was casa referred to medical examiner?

26. Piace of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

1 Yes 2 No

Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

29a. Cartifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

9000 Cherie 40400 Franklin 32. Registrar's Signature MJG2'5 31. Date filed (Month. 1999

State Registrar

DHMH 16 Rev 6/95

COMMINS Baltimore, Director

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Completed

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Hygiene. other than

Department of Health and important: if them 27 te m any Injury or other traum 2008.

physician the burial

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Completed

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Physician /Medical **Examiner** ician and burial-transit

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Physician: this After

Division or Attending 24 hours after death. Funeral Director: A

filled in by To the Hospital

within 2 To the

3 ☐ Suicide

27. Menner of Death

4 T Homicide

1 Natural
2 Accident

6 Could not be determined

5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

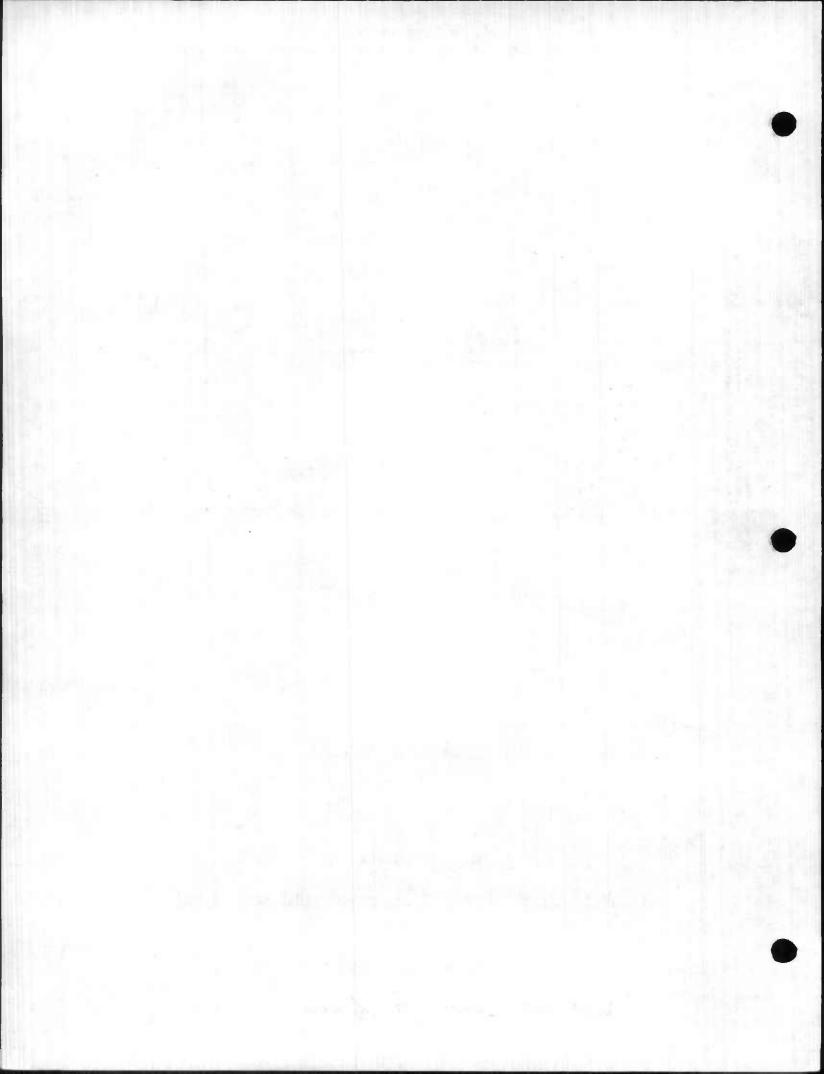
28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Square Drive Baltimore,



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physic /Med	cian	1. Decedent's Name (First, Middle	n fanti						Reg. No.		
/Med	eran -		e, Last)					2. Date of Dea Month	ith Day	Year	3. Time of D
		Mary		Din	gle			Aug	21	1999	2:10
Exam		4a. Facility Name (If not institution	The sales and the sales)			4b. City, Town, or		4c. County	of Death	
		Saint Agnes Hes					Baltimo				
Funera Directo		5. Social Security Number 214-22-5992 Usual Residence of Decedant	6. Sex 7. A 1 ☐ M 2 ☐ F	ge (In yrs. le		Under 1 Year onths Days				9. Birthple Count M •	
fand		10a. State 10b. County		10c. City,	Town or Location	on				10	d. Inside City
the Marylan 28a-f show	to	MD	NA	Bal	timore						Mayes 2
or 284	Director	10e. Street and Number				Of. Zip Code			10g. Citizen of N	Whet Count	ry?
with 72 hours after death with the Maryland liens. 'then "netural', or items 23s or 28s-f show tra Madical Examinal be notified at	Funeral	312 North M	ried 1 Yes 2 V	7	If Yes	2123 Decedent of Is, specify Cub	Hispanic Origin? (5 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	U S 14. Rad Blac Specifi	e - America ck, White, e	
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f Haalth item 27 other tr		Elijah Dingl 20a. Method of Disposition	e-Husband	20h Pla	312 N aca of Disposition	 Mona Name of 	astery	Ave, Ba	1timor 20c. Location	e Md	2122
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Department important: any injury		21. Signature of Funeral Servica	Licansee		22. Na Mai	me end Addre	H West				
105 8 0		Maine	XtV	0_			oash Av	e. Balt	imore	МД	21215
	V	23 Pant, Enter the disease, of shock, or heart failure. List	complications that cause	d the death.	Do not enter th	e mode of dyl	ng, such as cardia	c or respiratory er	rest,		Approximate Interval Betwe
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/Medical		Immediate Cause (Final disease or condition		Hone	tarelly	lac Fu	scinorra				3 Mont
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r this	 	27. Menner of Death	28a. Date of Inju	ury :	28b. Time of	28c. inju Wo		28d. Describe h			/
r daath. ector: Aftar by the funar	tior	Neturel 5 Pendin	g (Month, De	ey Year)	Injury		rk?]Yes 2∐No				
within 24 hours aftar death. To the Funeral Director: At completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ		28f. Location (S City or Tow		er or Rurei	Route Numbe				
Funeral Funeral	edical C	(Check only 2 Medical	g Physician: To the best Examiner: On the basis of	of examination	ledge, death occorn and/or investi	curred et the ti gation, in my o	me, dete and plecopinion, deeth occi	e, end due to the d urred at the time, d	euse(s) end me	enner as sto and due to	eted. the cause(s)
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\		30. Name and address of person,	Ave Sa	inta	cues						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. AUG BENNIE DIXON 1999 11:00 PM 20 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE PATAPSCO BALTIMORE W. If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Min. DEC. 24, 1927 South CAROUNA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Days 248-36-3016 10 M 2 F Months Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits Yas 2□No MARULAND 10e. Street and Number 10g, Citizen of What Country? 2602 PATAPSCO AVENUE USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 120 Yes 2 \(\text{DN} \) 0 /2 -50 If Yes, Give Yaar or Datas: // -2/-56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ejementery/Secondary (0-12) College (1-4or 5+) W, T, BENNETT 4CO 6 HHGRADE 17. Fathar's Name (First, Middla, Last) BUCK MARYBELLE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) Date 20c. Location - City or Town, Stata PALACE DIXON WIFE 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 4 Donation GARRISON FOREST (EME, 8-26-99 OWINGS MILLS, MD. 22. Name and Address of Facility 22. Name and Address of Facility 21.40 N. FULTONAVE 21. Signature Funeral Service Lice BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that wised the death. Do not enter the mode of dying, such as cardiac or respishock, or heart failure. List only one cause on each line. Approximate the three th · METASTATIC PANEREATIC ADENICANCINOMA Immediate Cause (Final 4 WEEKS disaase or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 3 Probably 4 WUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 W Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide

Box 68760. Division of Vital Records, P.O. **Physician**

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Examiner

Funeral

Director

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Certification:

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29a. Certifier

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permit. Peges 1 and 2 should be filled within 72 hours after. Department of Health end Mental Hygiene. If them 27 is marked other than "natural", or its

Maryland 21215-0020

Baltimore,

State Registrar 29b. Signature and title of cartifier nederch B

29c. License number 150500

IV certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 25, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FEDGUCKB. FOTLER GREENE STREET_ BAZTIMORE 21201

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 25 1999

To the Hospital or Attank within 24 hours efter deel To the Funeral Director:

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death lent's Neme (First, Middle, Last ARU **Physician** 3:15 PM 1999 nne /Medical 4b. Sity. Town, or Location of Death ot institution, give street and number) 4e Facility Neme (A) 4c. County of Death Examiner P MORE 10 nder 24 Hrs. 8. Dete of Birth Month, Day, Security Number If Under 1 Ve Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months -20-10 M 20 F Yrs Director 15W Usual Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Term or Location 10d. Inside City Limits ahow r than "natural", or flems 23a or 28a-f ahor the Medical Examiner must be notified at 1 Ves 2 No Director 10e. Sir 10f. Zip Code et and Number 10g. Citizen of What Country? 2/2 0 Funeral venue 11. Merita Stetus 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Méxican, Puerto Rican, etc.) Race - American Indian, Black, White etc. 1 Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 the Yes, Give Yeer or Detes: 2 10 No 1 Never Merried 2 ☐ Married 10 21215-0020 1 Yes 2 16 Specify py 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. PO NOT use refired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry un known Elementary/Secondery (0-12) College (1-4or 5+) Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be end Mental hao Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. leformant's Name/Relationship (Type, Print) -Department of Health e Important: If ham 27 la any Injury or other trai 11 Ams 20b. Plece of Disposition (Name of Method of Disposition
1 ■ Burial 2 □ Cremetion 20c. Location - City or Town, Stat 3 Removel from State 4 ☐ Don#ion 5 ☐ Other (Specify) of Moneral Service Lice see 23a. Part1. Enter the disease, or complications that desired the deeth. Do not enter the shock, or heart feilure. List only one cause on each line. on Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel Aspitation 1 hour disease or condition resulting in deeth) Examiner Physician/Medical Examiner Bleedina 1 days Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Danne Hospital or Attending Physician: Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Pinpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 (Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be 28l. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier completaly To the 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) D\$2544 23, 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 500 Ne Rolling Road, Enite 4, Catonsville, MD 21228 hep, M.D. Bewamin co. Registrar's S State Registrar

DHMH 16 Rev 6/95

AME

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month **Physician** 24 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) If Under 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs, last birthday) Days 213-88-Months Hours 1 M 25/ 0/8 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Merital Status Armed Forces Black, White, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married african 1 Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ustodian 17. Father's Name /First, Middle Last 18. Mother's Nema (First, Middle, Maiden Sumame))d a 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 160 MP21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositio 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MD21217 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that only one cause on each line. Approximata Interval Between Onset and Deeth CARDIO PULMORAR Immediate Cause (Finel diseese or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IMMUNDDEFICIONCY STRARDME

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. International Programment of Health and Mental Hygiene Transfeed other than "natural", or florms 23a or 28a-f ahow any Injury or other tranmatic event. In Medical

Baltimore, Maryland 21215-0020

an/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the bursal-transit

Division of Vital Records, P.O. Box 68760,

Part II. Other algnificant conditions	contributing to death but not re	sulting in the underlying	g causa given in Part I.	23b. Did tobacco usa co	ontribute to the cause of death? 3 Probably 4 Dunknown
				24a. Wes an autopsy performed?	24b. Wara autopsy findings evailable prior to completion of cause of death?
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27. Manner of Death 1 🖾 Neturat 5 🗆 Pending 2 🗀 Accident investigati		28b. Tima of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	med
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State Registrar

Me

29b. Signature and title of certifie

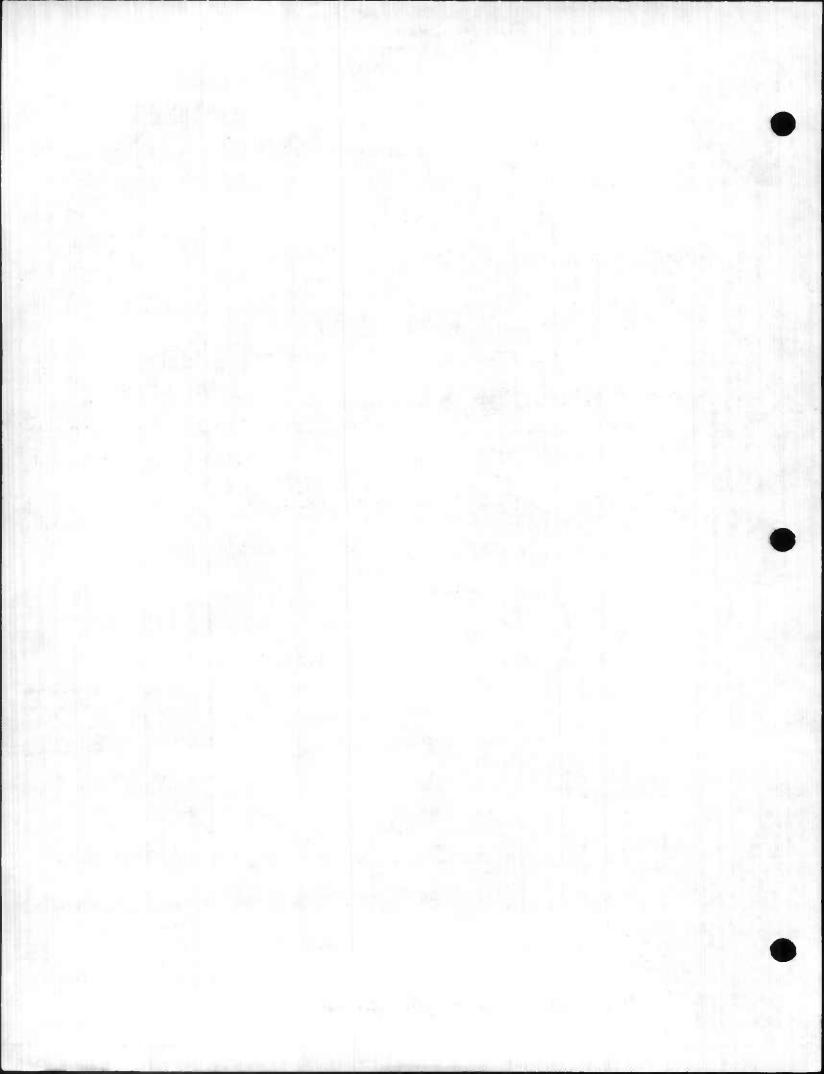
who completed cause of death (Item 23a) (Type, Print)

MD

2000 WEST BALTIMORE STREET BAUTIMORE MARYLAND

29d. Date signed (Month, Day, Year)

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth corge Hugust 21 1999 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth n Hospita 7. Age (in yrs. lest birthday) NA Allimore (good marilon If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) Rebrung ZZ, 191 If Under 1 Year Months Deys 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) Sex 1 DM 2□ F Months 154-09-3330 Usuel Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTimore MUD 18 Yes 2□ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21206 45A 1000 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Reca - American Indian 1 Never Merried 2 Married 1□ Yes 2⊡ No Specify If Yes, Give Year or Detes: 4'5 divorcad 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Auto NA 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) LAK 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) lier 34 market Place BATTime MD 21202 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State Blackwell-Grandis Wanda 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Gion 8-24-99 Comsdome (nD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Albert P. Wylie 7/14 PA Gilmor Street BATTIN CMD. 21217 638 N. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting In deeth) . SEPSIS 1004 Due to (or es e consequence of): 3 DMS ASPIRATION PNEMMUNIA Due to (or es e consequenca of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy 24b. Were autopsy findings MUNUNS PLUGUNG evailable prior to completion of cause of deeth? performed?

Physician /Medical Examiner

any Injury or c

Physician

/Medical

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Director

Funeral

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item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic svent, if a Medical Examinar must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours aftar Department of Heelth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or its

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Examiner signed by the attending physician and I be detached for use as tha buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical

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Certification:

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2 Accident

3 ☐ Suicide

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Annins Cunine condinusculm DISEASE 25. Was case referred to medical exeminer?

Dete of Injury (Month, Day Year)

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Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

28c. Injury et Work?

29b. Signature and title of certifier

5 Pending Investigation

6 Could not be determined

29c. License number 15135

29d. Dete signed (Month, Dey, Year) AMOUST 23, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SCOTT MD 564 WILL MAN SLID BATHUME, MD 21234

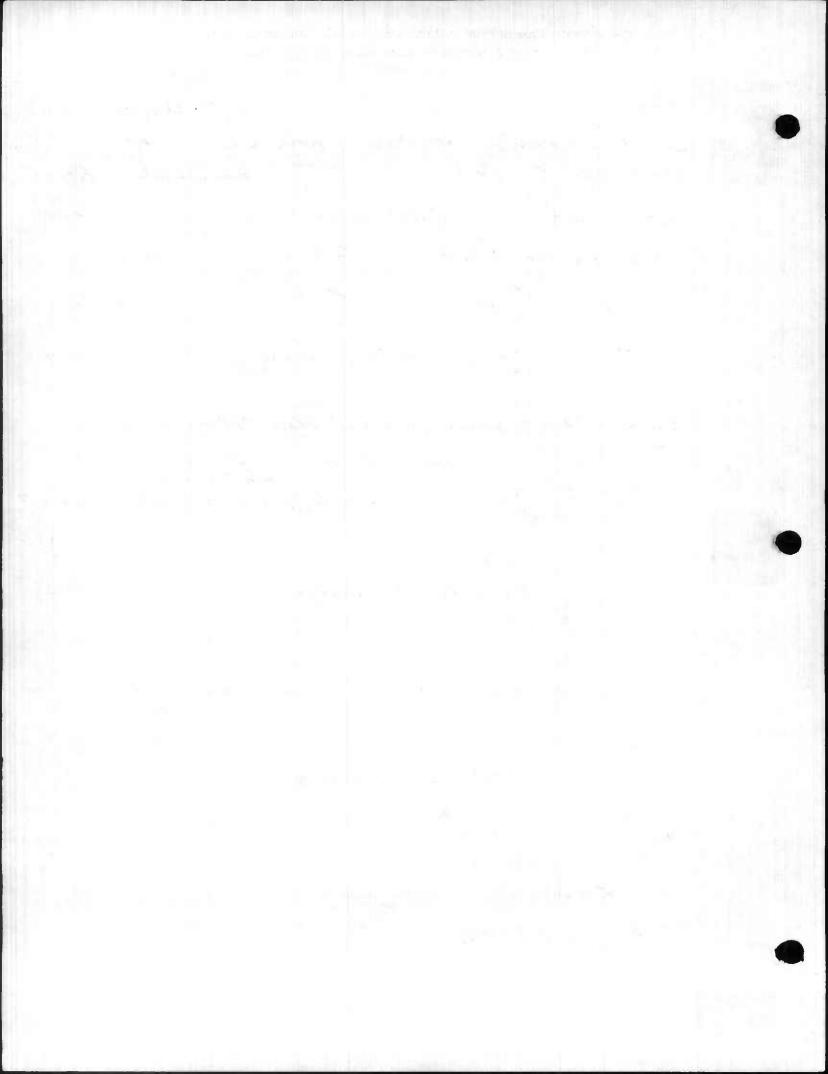
State Registrar

2. Registrar's Signature

1 Inpatient 2 ER/Outpetient 3 DOA

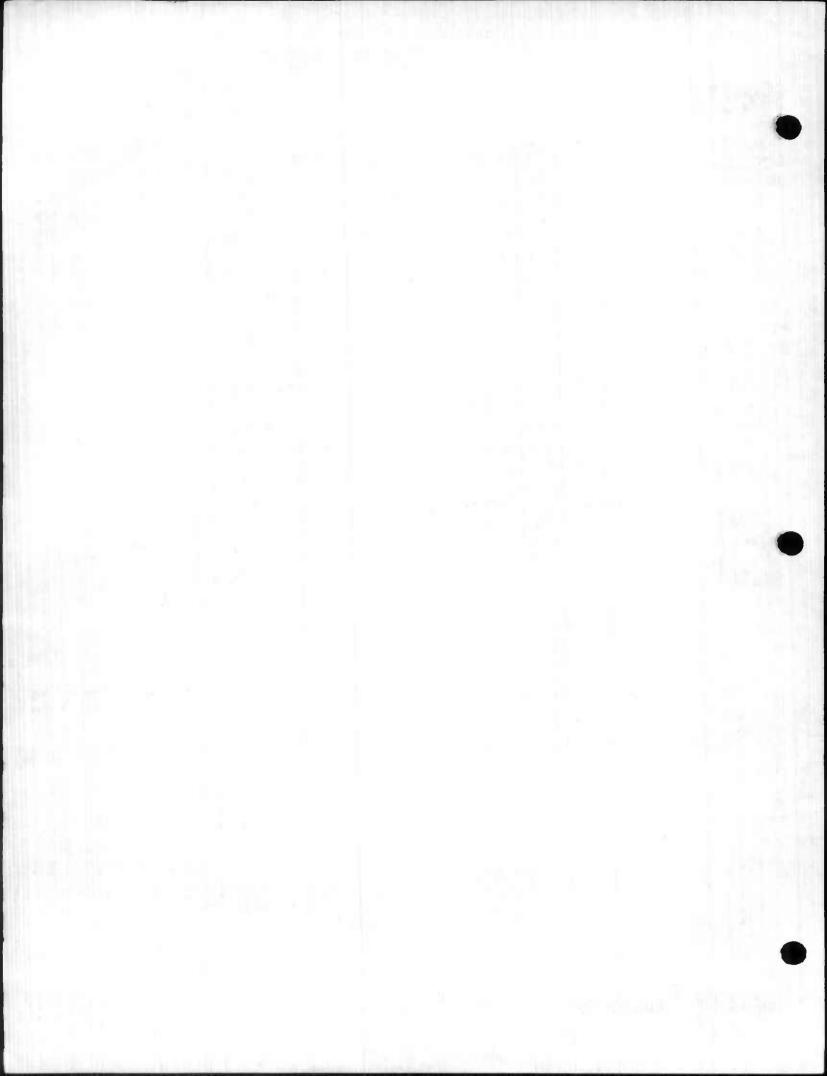
28e. Pleca of injury - At home, farm, street, factory, offica building, etc. (Specify)

To the Hospital or Attanding Ph within 24 hours eftar death. To the Funeral Director: Aftar thi completely filled in by the funeral



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	within To the comple	Me	29b. Signatura and titia o	f certifiar	and manner ster	/ A		29	c. Licensa	number	T	29d. Date signed	(Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 9 26638

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** AUGUST 22, 1999 MARY FREEDLANDER 3:45PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner JEWISH CONVALESCENT HOME BALTIMORE BALTIMORE 8. Data of Birth (Month, Day, Year) OCT 23, If Under 24 Hrs. If Under t Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Deys Months Hours 89 216-36-7655 1909 Director Usual Residence of Decedent 10a. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 X Yas 2 No must be notified Director MD N/A BALTIMORE 23s or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 CLARKS LANE #211 21215 U.S.A. Funeral Was Decedent Evar in U,S. Armed Forcas?

1 Yas 20 No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens. 1 Nevar Married 2 Married b Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: WHITE þ Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hypiene. Elementery/Secondary (0-12) Collega (1-4or 5+) HOUSEWIFE OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Be DAVID KANTER RACHEL BERKOWITZ 2 and s 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Department of Health Important: If Item 27 DAVID FREEDLANDER / SON 2400 BARE ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata HAR ZION TIFERETH ISRAEL 8/24/99 ROSEDALE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 10 23a. Part F. Entar the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): and P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by the page 2 should be detached 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No I or Attending Physician: after death.
Director: After this certifica funeral director, 25. Was casa referred to medical 26. Place of Deeth (Check only one) axaminar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medicai Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident ompletely filled in by the 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

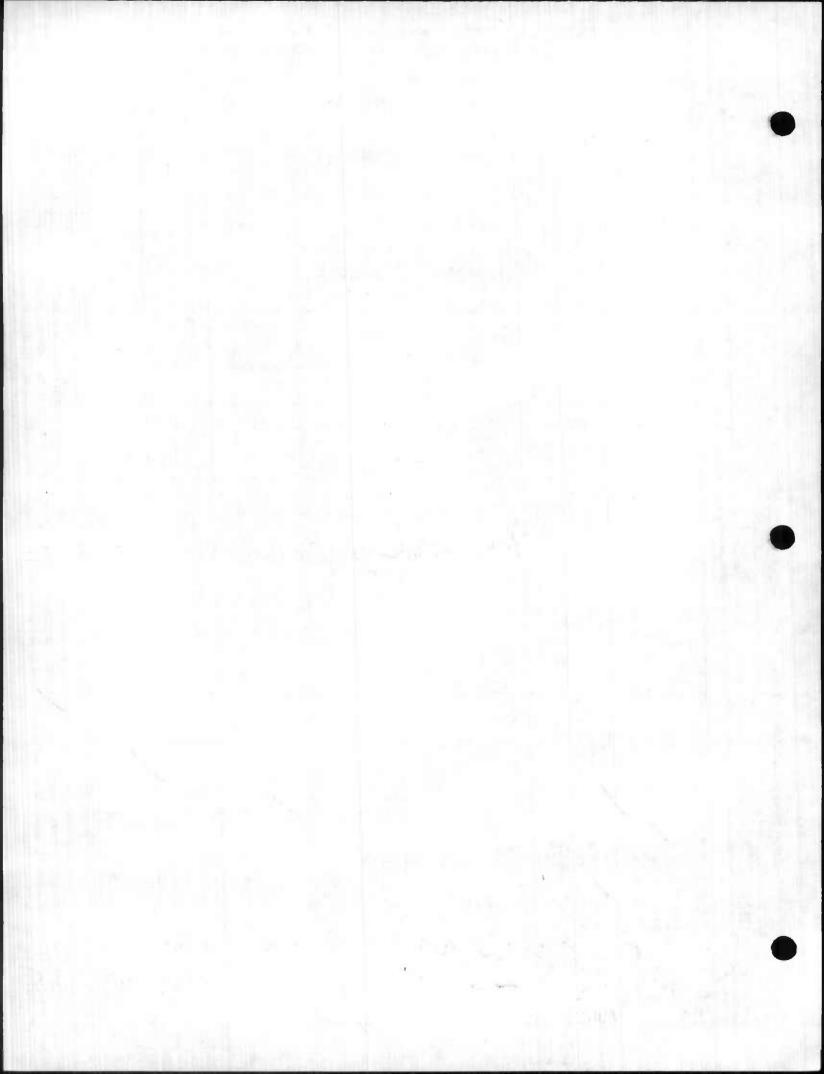
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier 29b. Signatura and titla of certifiar 29d, Data signed (Month, Day, Year) 29c. License number 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) MI

DHMH 16 Rsv 6/95

State Registrar 31. Data filed (Month, Day, Year)

AUG 25

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

	Decedent's Name (Fig. 1)	îrst, Middle. La	st)		Cer	tificate of	Death	2. Date of	Reg. No.		3. Time of Deeth	
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xaminer	4a Facility Neme (If not 2805 P:	-						n, or Location of D imore		Oounty of Death		
eral ctor	5. Social Security Numb		ax M 2□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Dete of Month, 4 – 4	Birth Day Year)	9. Birth	plece (State or Foreign	
	Usual Residence of Dec	cedeni b. County		12-	r, Town or Lo	cation					10d. Inside City Limits	
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Director	10e. Street and Number			, Du	1011110	101. Zip Code			10g. Citize	en of Whet Cou	ntry?	
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by runeral	11. Marital Status 1 ☐ Never Married 3 🛣 Widowed 4 ☐		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 X No	H	Ves Decedant of I Yes, specify Cub ☐ Yes 2∑ No	an, Mexican,	n? (Specify Yes of Puerto Rican, etc.	Black, White, etc. Specify: Black			
		Decedent's Econly highest gra			16a. Deced	ent's Usual Occup	pation	of working	Black 16b. Kind of Business/Industry			
Completed	Elementery/Seconder	1-4or 5+)		kind of work done OO NOT use retire		or working						
	8th grad		na		Cran	e Opera		s Neme (First, Mic			emical Cor	
To Be	Rev. Will							Suzie				
	19a. tnforment's Name/				19b. Meilin	g Address (Street		or Rural Route Nu		Town, State, Zij	p Code)	
	Richard G		n Jr				stman	St. Ba				
	20e. Method of Dispositi		Removal from	C4	ace of Disposementery, crem	sition (Neme of natory or othar pla	ica)	Date	20c. Loca	ation - City or T	own, State	
	4 ☐ Donation 5 ☐	Other (Specify	y)		dlawn	Cemete	ery	8/27/9	99 Bal	timore	e Co. Md	
	21. Signature of Funera				M	Name and Address arch F	H WAS	st				
	March F/H West 4300 Wabash Ave, Baltimore Md 23a. Parl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line.											
Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last		a.	Due to (or	r as eregnsed or es e consed as a consedu	uenca of):	7.79	ilure				
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Be	25. Was case referred to examiner?	to medical	Hespitali					of Deeth (Check o	nly one)			
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ition		☐ Panding Investigetion	(Mor	nth, Day Year)	Injury	28c. Inju Wo M 1	ork?]Yes 2□N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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edical			niner: On tha b	asis of axaminet				plece, end due to occurred at the ti				
Me	and manner stated. 29c. Licanse number 29d. Date signed (Month										, Day, Year)	
	> X	2 11	10	40	2 1	1 (05	482	9	08	104/	99	
	Name and address of	of person who	completed clu	se of deeth (Item	23a) (Type, I	2435	· W.,	BEIVE	DERE	- Ava	i. 21d15	
State	31. Date tiled (AUG	2 5 199	9 328	agistrar's Signet	ture 5.	porks	1					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** 4b. City, Town, or Location of Death Alice HArrington 0000 21 /Medicai 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner 2401 W. Belydere Hunder 1 Year Sina HOSpital 5. Social Sacurity Number 6. Boltimore If Under 24 Hrs. 8. Dat Hours Min. Birthplaca (Stete or Foreign Country) Months Days 217-28-5192 1 ☐ M 2 🗷 F Director Usual Residence of Decedent 10a. Stata 10b, County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Yas 2 No MARYLAND Directo 10a. Street and Number 10g. Citizen of What Country? 6 HVENUE Неттв 23а USA. 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No ŏ 1 ☐ Yes 2 XNo Specify: Specify: BLACK by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 ++GRADE College (1-4or 5+) JANITORIAL WORK SELF-EMPLOYED 17. Fether's Neme (First, Middle, Last) WILLIAM ALICE (MN-UNKNOWN) 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ULYSSES HARRINGTON (HUSBAND) 5319 WESLEY AVENUE, BALTIHORE, HD. 21207 ace of Disposition (Name of Date 200. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEMETERY 8-28-99BALTIMORE, MARYLAND 4 Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSE PH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Lest and Due to (or es a consequence of): Box 68760 physician Physician/Medical tha Due to (or as a consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 🗆 No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated. 29e. Certifier (Check only 29b. Signatuge certifier 29c. License number 29d. Date signed (Month, Day, Year)

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2401 W. BELVE DERE, BALTIMORE, MD. 21215

State Registrar MCGADOL

AUG 25 1999

31. Date filed (Month, Dey, Yeer)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

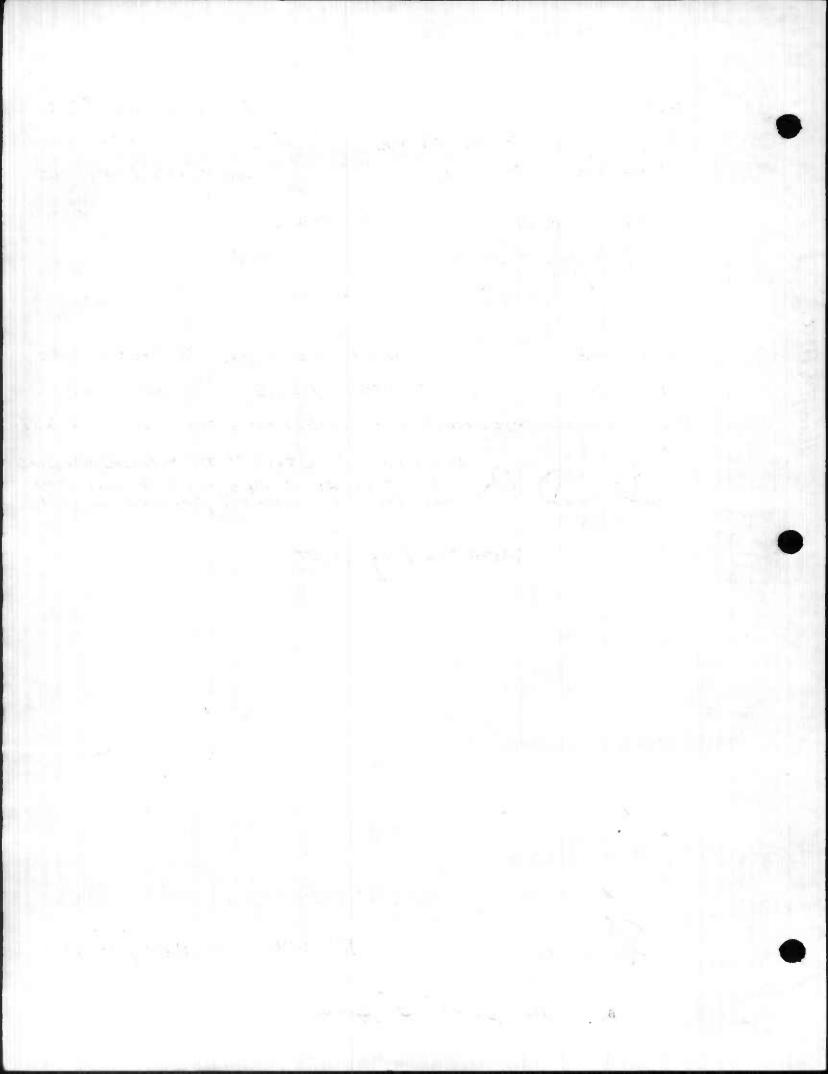
HOSPITAL

32. Registrer's Signature

SINAI

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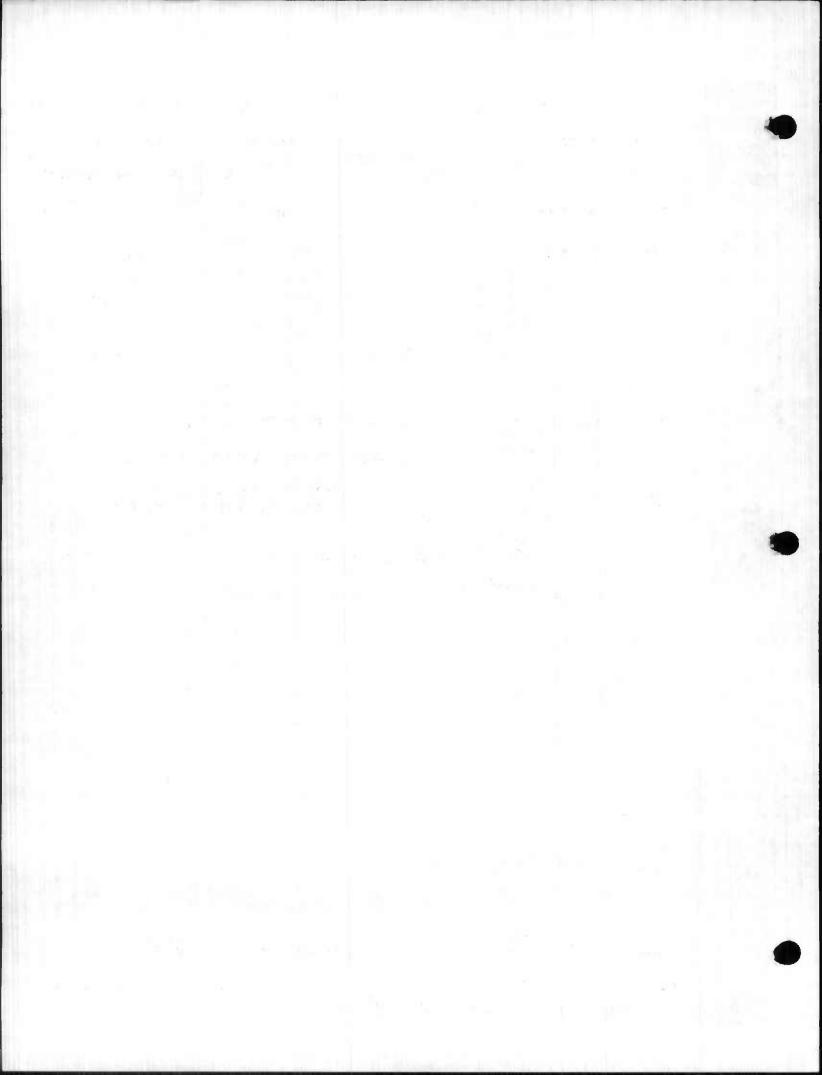
Upraing Tan, Alice



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:30 m AUGUST EVELYN B HATLEY 1999 /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1200 Magness Court Harford Belcamp. If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 □ M **2K**F Days 242-26-2555 Yrs. 73 Director June 13 1926 North Carolina Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Md HArford **Belcamp** 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Magness Court 21017 USA death Funeral itams 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes X ☐ No Specify: Specify: þ White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th own home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marvin A Brown Anna Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Deborah McFadden / daughter 1200 MAgness Court BelCamp Md. 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Cemetery 8/24/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that ceused the death. So not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only prie cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner sician end buriei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting In death) Last physician s the burie Box 68760, Due to (or as a consequence of): 80 use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown bengis Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medicel examiner? a 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 24 hours after death. Puneral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medical 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Silver, mD 2411 W Belveretue BAHO, MD 21215 31. Date tiled (Month, Day, Year) AUG 2 5 1999 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death HUNTZBERRY 3-40 P.M JAMES 1999 AUGUST 20 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) BALTEMORE HOSPITAL CENTER HARBOR If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Stefe or Foreign Country) 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. lest birthdey) Months June 27, 1951 Maryland 212-58-8211 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County N☐ Yes 2☐ No Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3623 Leo Street U.S.A.

14. Rece - American Indien, 21226 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merilel Stetus Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Tow Truck Driver 8th Self Employeed 0 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Edward Τ. Huntzberry Bertha Mae Herberson 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sandra Huntzberry (Wife) 3623 Leo Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park | 8/24/99Glen Burnie, Maryland 21. Signeture of Funeral Service Licensee 32. Name and Address of Fecility McCully-Polyniak Funeral Home, P.A. d. Hetter 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY disease or condition resulting In deeth) CIRRHOSIS IVER Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thel initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred

Physician /Medicai Examiner

Important: If it any Injury or o

permit. Pege Department

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Heelth and Mentel Hygiene.

ant: If item 27 is marked other than "naturel", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinating near the notified as

Baltimore, Maryland 21215-0020

Examiner ettending physicien end for use es the buriel-transit signed by the e

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

is certificete has director, page 2 After this funeral n 24 hours efter deeth.

Funerel Director: All pletely filled in by the fu deeth.

Physician/Medical þ Completed Be Certification: To

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No

27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 ☐ HomicIde

5 Pending Investigation 6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, streel, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Streef end Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier Anita nahar, HOUSESTAFF INT. MEDICINE

29a. Certifier

(Check only one)

29c. License number 10056

20,1999 AUGUST

29d. Dete signed (Month, Dev. Year)

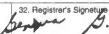
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ANITA NAHAR, 3001 S. HANDVERSTREET, BALTEMORE MD 21225

State Registrar

edicai

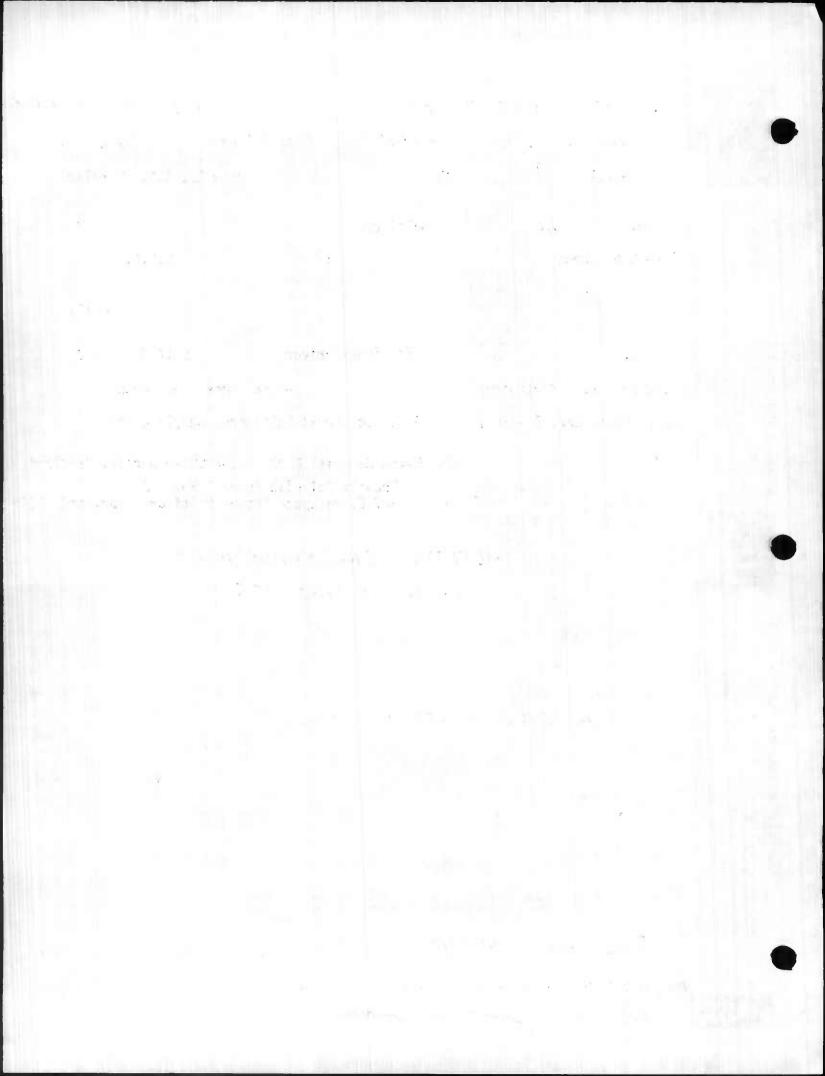
31. Dete filed (Month, Day, Year) AUG 2 5 1999



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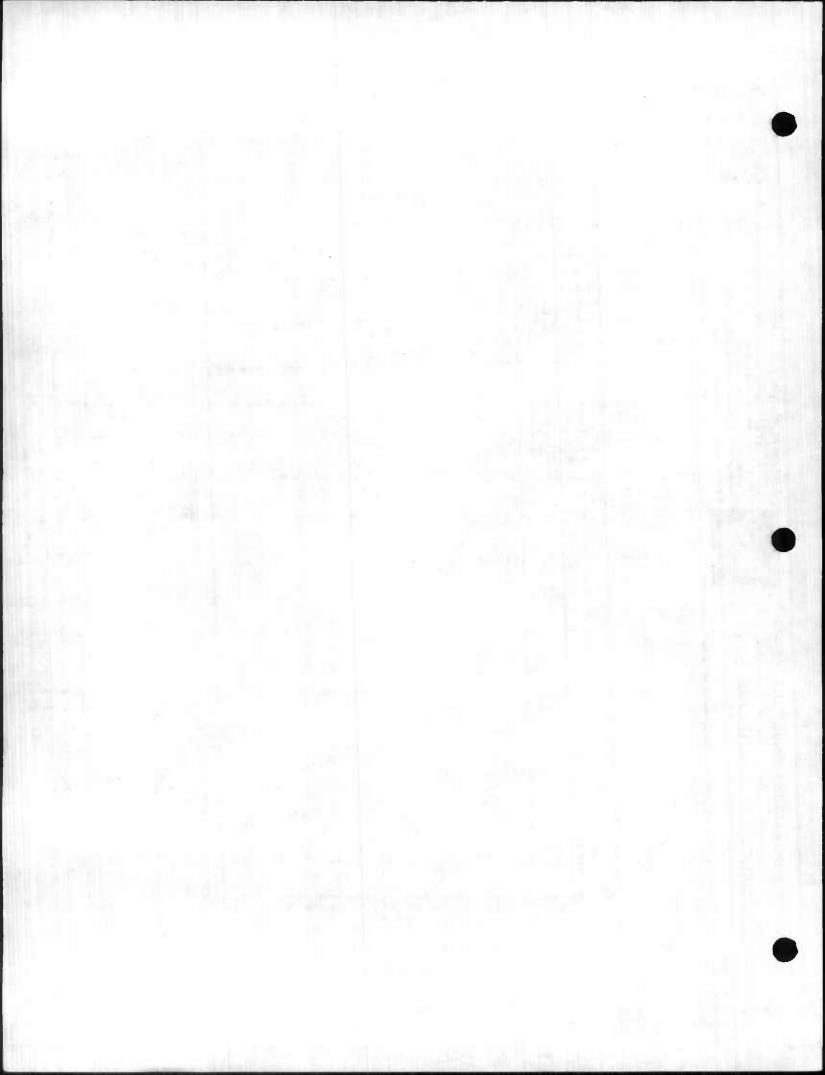
To the Hosp within 24 hor To the Fune completely fi



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State of Maryland / Department of Health and Mental Hygiene 9 266 4

			C	ertificate	of Death	R	eg. No.		W 1
Physician /Medical	Decedent's Name (First, Middle, Las BETTY	LOIS		HAPPEL		2. Data of Deal Month AUGUST		Year 9	3. Time of Death 9:00 PM
xaminer	4a Facility Nama (If not institution, give				4b. City, Town, or	Location of Death	4c. County of	of Death	/
al or	212-20-3532		yrs. last birthd 72 Yrs	Months D	LINTHIC Fear If Under 24 Hrs ays Hours Min.		Year)	9. Birthpl Count	NDEL lace (State or Foreign try) SYLVANIA
-	Usual Rasidence of Decedent 10a. State 10b. County		c. City, Town o					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
/ Funeral Director	MARYLAND ANNE ARI 10e. Street and Number 8025 QUARTERFIELD			SEVERN 10f. Zip Co	de 21144	1	0g. Citizen of W		
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	in U,S.	3. Was Decedent if Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No- lo Rican, etc.)		, Whita,	an Indian, etc. ITE
Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	(G	cedent's Usual O ive kind of work of e. DO NOT use r EMAKER	ocupation lone during most of wo etired)	rking	16b. Kind of Bus	HOM	
Be	17. Fathar's Nama (First, Middle, Last)				18. Mother's Nar	ma (First, Middle, I			
2	GEORGE E.	WAI	1		EDNA	М.	0: -		PPER
	19a. Informant's Name/Ralationship (7 MR. WILLIAM DEMAS:			-	treet and Number or Re ENUE,BALTI				
	20a. Mathod of Disposition \$\infty \text{Burial} \text{ Burial} \text{ 2 \textstyle Cramation 3 \text{ 4 \textstyle Donalion 5 \text{ Other (Specify)}	Ramoval from Stata	Ob. Place of Di	sposition (Name commetory or other	of place)		20c. Location - (City or To	wn, State
DOCE.	21. Signature of Funaral Service Licent			22. Name and A	ddress of Fecility AVENUE, S	SINGLETO	N FUNER	AL H	OME, P.A.,
Examiner	23a Fam. Enter ha disaase, or compensation, or heart feilure. List only of limited the condition resulting in death)	· Wult	to (or as a con	My	elong				Intarval Between Onset and Death 2 y ears
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	С.	to (or as a con						
y Physician/M	Part II. Other significant conditions co	ntributing to death but no	t resulting in th	e underlying ceus	e given in Part I.	23b. Did to	obacco use con	tribute to	the cause of death?
by Phy					1 🗆 Y	es 2 No	3 Prot	bebly 4 Unknown	
pleted				-4		24a. Was a perform		ave	era autopsy tindings allable prior to inpletion of cause death?
Com						1 □ Y	es 20 No	1 🗆	Yes 20 No
o Be (25. Was casa referred to medical examinar?	Hospital:	۵۵۶۵۸	* all pos	Other	eth (Check only on		- 1011	
- I	27. Mannar of Death Natural 5 Pending invastigation	1 ☐ Inpatient 28a. Dete of Injury (Month, Day Ye	2 ER/Outpa 28b. Tim tnju		Injury at Work?	forme 5 ☐ Reside 28d. Describe he			0
Certification:	3 Suicide 6 Could not be datamined	er or Flura	al Route Number,						
completely filled in by the funeral Medical Certification:		reician: To the best of my Iner: On the besis of axa and mannar stated.							
W	29b. Signature and little of certifier	Storge W	9	0	cense number	2	9d. Data signed	(Month,	Day, Year)
/	30. Nama and address of person who co DR. PETER R. GRAZE				SUITE 300	ANNAPO	LIS MD	214	401
State	31. Data filed (Month, Day, Year)	Registrer's	in throtain	/	,	,	,		



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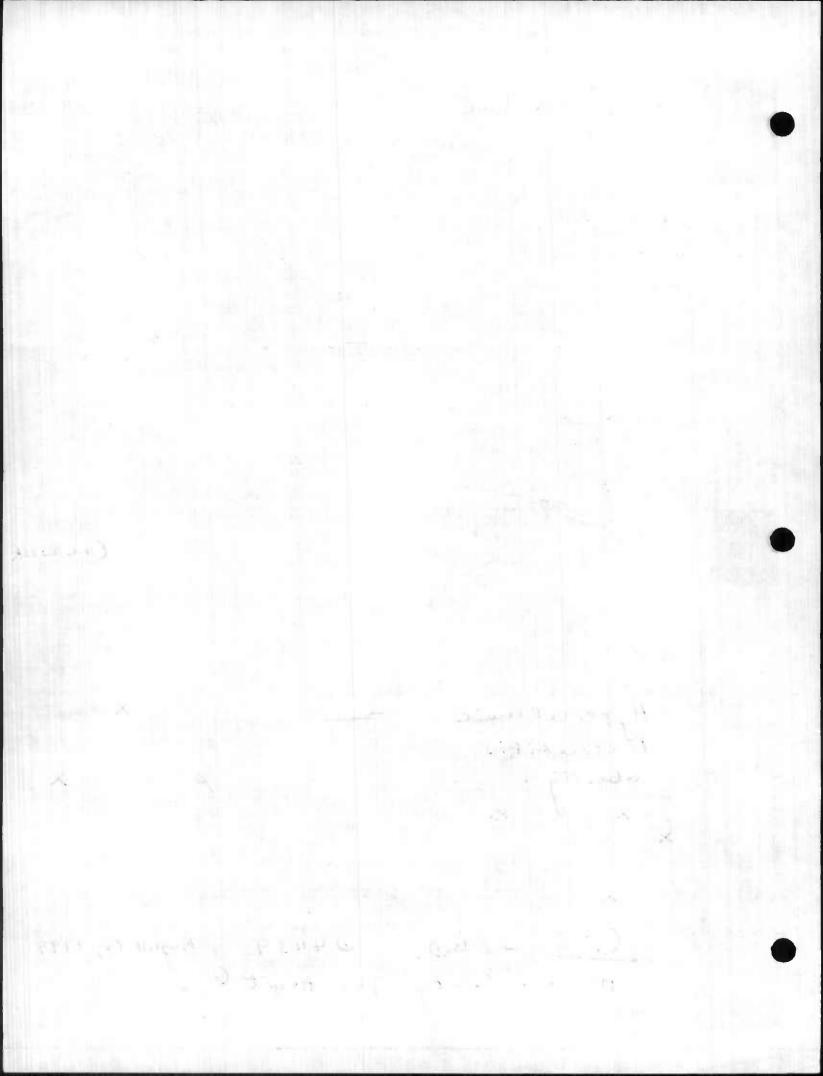
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marcia Hartlove 4:03 PM 4b. City, Town, or Location of Death 16th 1999 /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner Howara Columbia Hospital County General Howard (
5. Social Security Number if Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 F Days Months Hours 216-48-9251 Director 47 TURKEY 06-29-1952 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes X No Director HOWARD r 28a-f MARYLAND ELKRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 6525 FALLSTON ROAD 21075 U.S.A. Funeral Heme: 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus r than 'netural', or iter the Medical Exercioes Biack, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) SCHOOL BUS SCHOOL BUS DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be I nent of Health and Mental I int: If Itam 27 Ia marked of FRANK DANIELS, JR. HAZEL MOYER 19a. Informant's Name/Reletionship (Type, Print) (HUSBAND) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) WOODROW HARTLOVE, JR. 6525 FALLSTON ROAD, ELKRIDGE, MARYLAND 21075 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Buriai 2 ☐ Cremation 3 ☐ Removel from State 6 Department of Important: If any injury or 5 Other (Specify) 4 Donation GLEN HAVEN MEMORIAL PARK | 8/21/99 GLEN BURNIE, MD. 21. Signature of Funeral 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediete Cause (Finel ne week Metastatic Adenocarcinoma disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): USB Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown l cemia should be d Division of Vital Records. þ 24b. Were autopsy findings available prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 Obes il 2 No 1 Yes 212 No certificate or Attanding Physician: funeral director, 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: ixinpatienf Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a within 24 hours a To the Funeral C Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated. 29a. Certifier completely (Check only one) \$ 29b. Signature and pre-of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 August 16 M. 1) 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Cou How and 2. Registrer's Signatu State

DHMH 16 Rav 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** IDA MAE KIDD AUGUST 11:15 A.M. 22, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 BELVEDERE AVE. ANNE ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 10M 20 F 93 212-01-9426 Yrs Director MAR. 21, 1906 TENNESSEE Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow mast be notified at MARYLAND ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2 No Directo 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21061 UNITED STATES 6 BELVEDERE AVE. Herna 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Merital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 □ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) SALES CLERK WHOLESALE SALES 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be BETTY SAIFFLETTE THURMAN FERGUSON 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 QUEENS RD., GLEN BURNIE, MARYLAND 21061 BETTY BOWMAN / FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State AUG. 1999 GLEN HAVEN MEM. PARK GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 21061 0 23a. Part 1. Square the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Examiner lvulan 1 luy The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical Due to (or es e consequence of): for use as P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Hypertension of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No tal or Attending Physicien: T is effer death.

In Director: After this certificat ed in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending Investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier 1 Locatifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner steted. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23811 AUGUST 23, 1999 nathe rman My

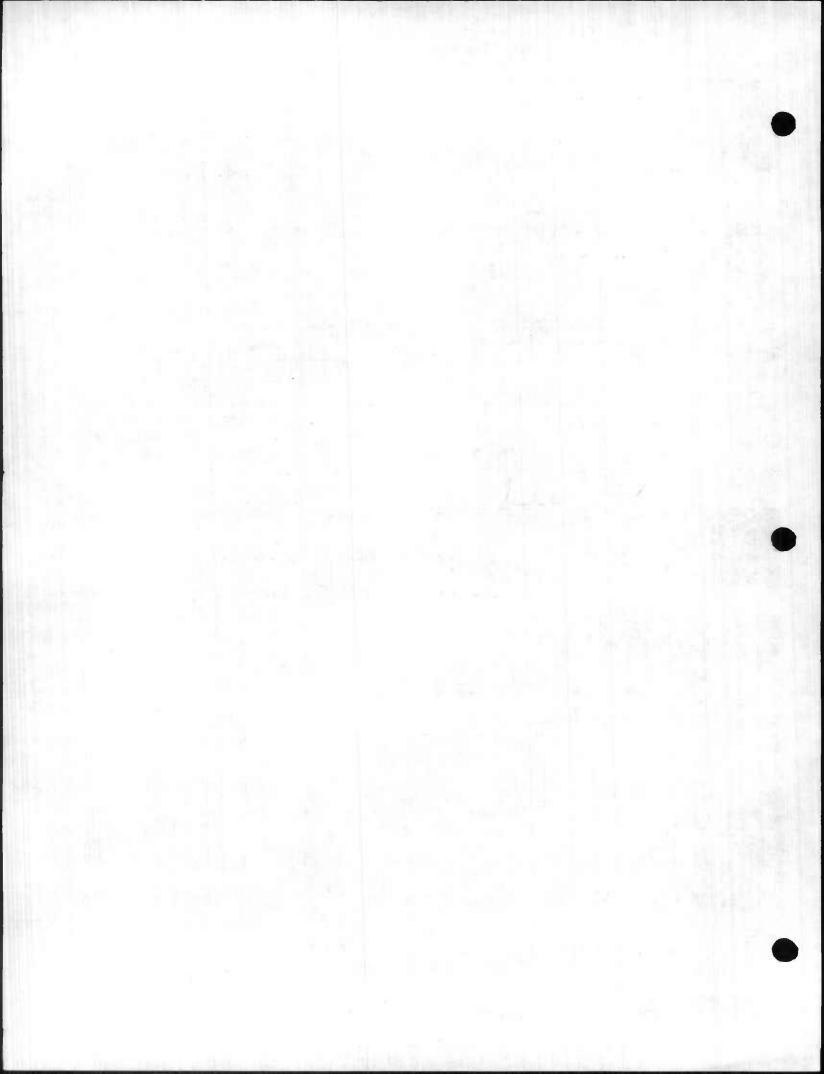
State Registrar

DHMH 16 Rev 6/95

FORMAN, M.D., 1406 B CRAIN HWY., SUITE 304, GLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) AUG 2 5 1999 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 26617 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Klaschus 4b. City, Town, or Location of Death 6,03pm 9 1999 4a Facility Name (If not institution, give street and number) 4c. County of Death St. Elizabeth's Nursing Home Baltimore If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□M 20 F 215-01-3623 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits St. Mary's Leonardtown 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1, Box 108-3AB 20650 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 Yes 22No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesperson department stores 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Palovis Vincent Waitukaitis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 811 Lee Avenue, Sykesville, Md. 21784 Raymond Klaschus son 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/23/99 Baltimore, Md. Most Holy Redeemer Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Witzke Funeral Home of Catonsville, Inc. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death Immediate Cause (Final · Serile Deuxentra, Alzheimer, End-stage Year-5 Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hillinown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa retarred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or flams 23a or 28a-f ahow explicitly or other traumatic event, the Medical Exercises must be notified at each page.

lanschus, Anna.

Anna

10a. State

Director

þ

Completed

8

MD.

11. Marital Status

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical by

1 Yes 2 No

27. Manner of Death

1 (Pratural

2 Accident 3 Suicide

4 - Homicide

29a. Certifier

disease or condition resulting in death)

physician and the burial-transit The lew requires that the death certificate be axecuted ... signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

P.O. Box 68760,

Records,

Division of Vital

DHMH 16 Rev 6/95

Completed 8 Medical Certification: To

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29b. Signature and litle of certifier

29c. License number D52544

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year) AUG, 20, 1999

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Catonsville UD 21228 Benjamin S. Lep, mis Rolling Rd #4. 500 N 31. Date filed (Month, Day, Year)

State Registrar

AUG 25 1999

5 Pending

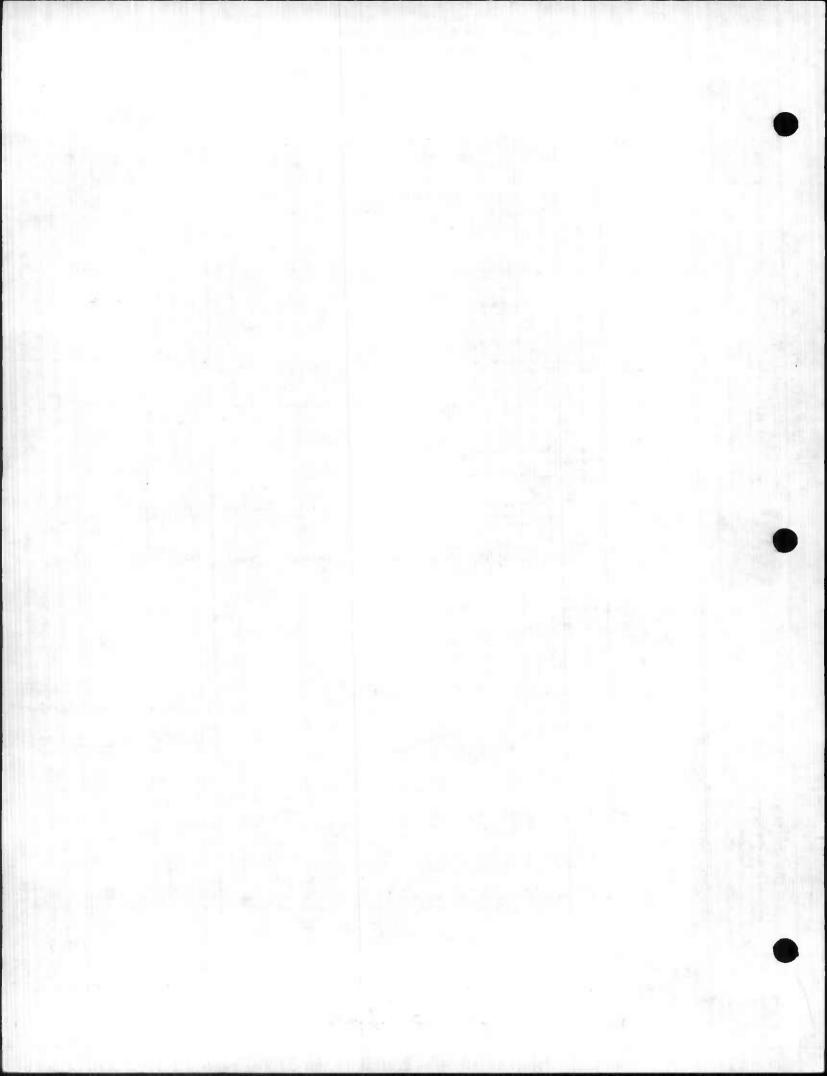
investigation

6 Could not be determined



28b. Time of

28e. Place of Injury - At home, term, street, tactory, office building, atc. (Specify)



State Registrar

completely

within 2 To the F

(Check only

29b. Signature and title of certifie

one)

MAMARIA -1025h 31. Date filed (Month, Day, Year) 32. Registrar's Signature

AUG 2 5 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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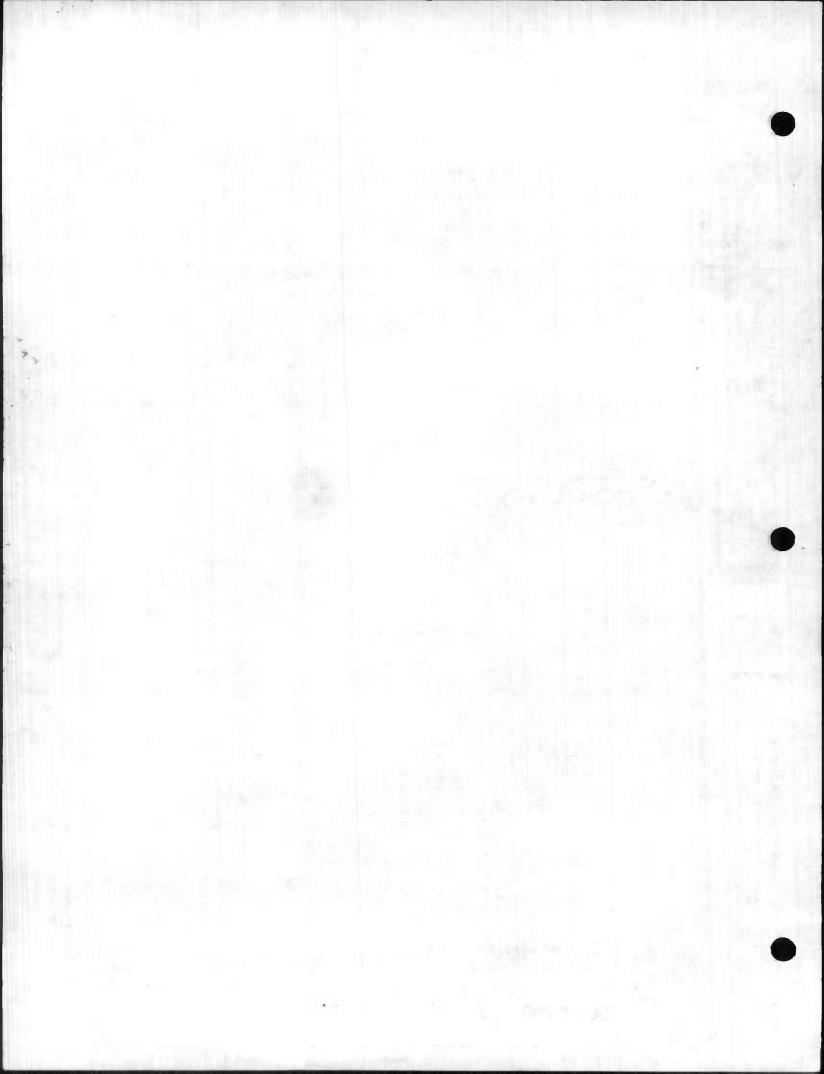
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 18, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death (First, Middle, Last) 2. Dete of Death **Physician** Karpowi CZ /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA ST, A9 5. Social Security Number H Under 24 Hrs. Hours Min. 8. Dete of Birth (Mohth, Day) Se (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) **Funeral** 215 Months Days -05-534 1 M 2□ F Director Usual Residence of Decedent the Mandand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Yes 2 No **Funeral Director** More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yas, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American India 11. Merital Stetus Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 9 1 ☐ Yas No Specify Completed by 3 □ Widowed 4 □ Divorced Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than 0 Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme Be tdam Karoou Cronica 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristen Comba 20b. Place of Disposition (Name of cemetery, cremetery or other 20e. Method of Disposition 20c. Location; City or Town, State Burial 2 Cremetion 3 Removal from State 들 Department of Important: If any Injury or 5 Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errast, shock, or heart fellura. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediete Ceusa (Final 4 days NEUMONIA diseese or condition rasulting in deeth) Examiner CONTRACTURE RELEASE Physician/Medical Examiner RIG-HT HIP MUIN KNEE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diaeese or Injury that initiated eventa reaulting in death) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 LNo 3 Probably 4 Unknown CEREBRAI PALSY Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? page 2 this certificata 2000 212 No or Attanding Physician: funeral director, 25. Was casa raferred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Metural 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 Could not be datermined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as atated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data end place, and dua to the cause(s) end menner steted. 29a. Certifier (Check only one) 29b. Signature and title of eartifle 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

FRANKLIA

XAR DOWIEZ,

AME

DHMH 16 Rev 6/95

JOHN ANTOM ADO

3507

32. Registrar's Signeture

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

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PER CE DIA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26650 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Month **Physician** ua /Medical 4a Facility Name (If not Institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 more If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex If Under Age (In/yrs. last birthdev) 9. Birthplece (State or Fpreign **Funeral** 10-0088 Days Months Hours 1 X M 2 □ F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at No.Yes 2 No Director arv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0 d 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Race American Indien Black White etc. permit. Pages 1 and 2 should be fitted within 72 hours after. Department of Health and Mental Hygiene. Important: if flam 27 is merked other than "natural", or ites any injury or other traumetic event. 1 Never Merried 2 Merried 1 Yes 2 2 1 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) vere 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Maiden Sumemel Be 19a. Informant's Name/Relationship (Type, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Print) Zio Code) nez TO 20a. Method of Disposition 20b Piaca of Disposition (Name of Dete 20c. Location -City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State lem.rar 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Josep UR Nor Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot) physician sthe burial P.O. Box 68760, Physician/Medical Due to (or es a consequence of): been signed by the a should be detached t Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were eutopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? has page 2 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: 25. Was case reterred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 2 No Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 28h Time of 28c. tnjury at Work? 5 Pending investigation 1 TYes 2 No 24 hours after deeth. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifier 11 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, end due to the cause(s) and manner as stated completely 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the

State Registrar

29b. Signetur

DHMH 16 Rev 6/95

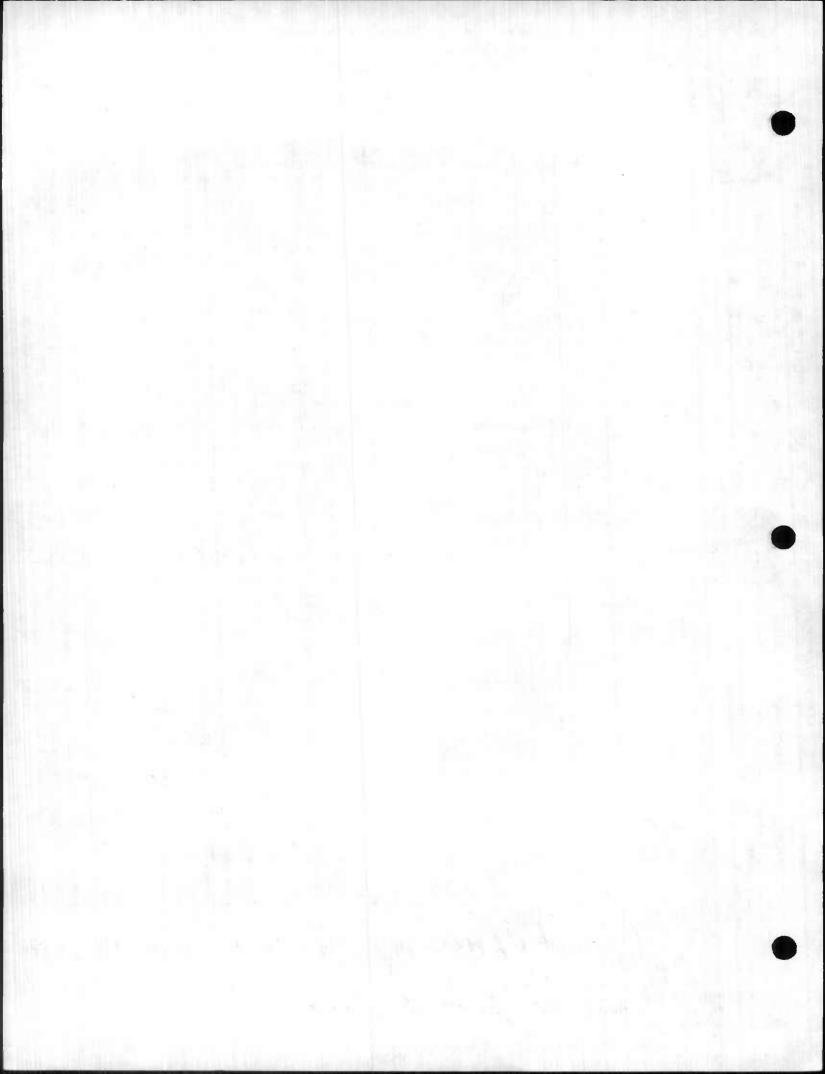
ath (Item 23a) (Type, Print)

Régistrar's Signature

32.

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1704 /Medical 4b. City, Town, or Location of Death Sacility Name (It, for Institution, give street and number 4c. County of Dea **Examiner** IONNS HOPKINS BAYVIEW EDICAL If Under 24 Hrs. 8. Date of Bir ISA TER If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months 1 □ M 2 💢 F Yrs 215-07-4268 85 July 11,1914 Director Maryland Usual Residence of Decedenf the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Inotified at ahow 1 Yes 2 No Directo Maryland Baltimore Edgemere 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? Herne 23a or the Medical Examiner must be 2825 Lodge Farm Road Apt. 112 21219 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: ğ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Se Contract Elementary/Secondery (0-12) College (1-4or 5+) 12 Years Homemaker Own_Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oths. Any Injury or other treasured. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 2 Matthew Connors Estella Franz 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Dolores M. Skalski 8157 Gray Haven Road Dundalk, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete tE Burial 2 ☐ Cremefion 3 ☐ Removel from Stete 4 ☐ Donafion 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 8/26/99 Dundalk, Maryland 21. Signature of Juneral Service Licenses 22 Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 eese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, tre. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final NEUMONEA disease or condition resulting in deeth) Examiner Examiner BROVASCULAZ burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lasf Due to (or es e consequence of): and physician s the burial Box 68760 Physician/Medical Due to (or es a consequence of): 88 attending 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Records, P.O. the th signed by t 1 Yes 25 No 3 Probably 4 Unknown by 24a. Wes an eutopsy performed? 24b. Were eutopsy tindings available prior to Completed Deen completion of cause of death? 1 Yes 25 No 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Neturel 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

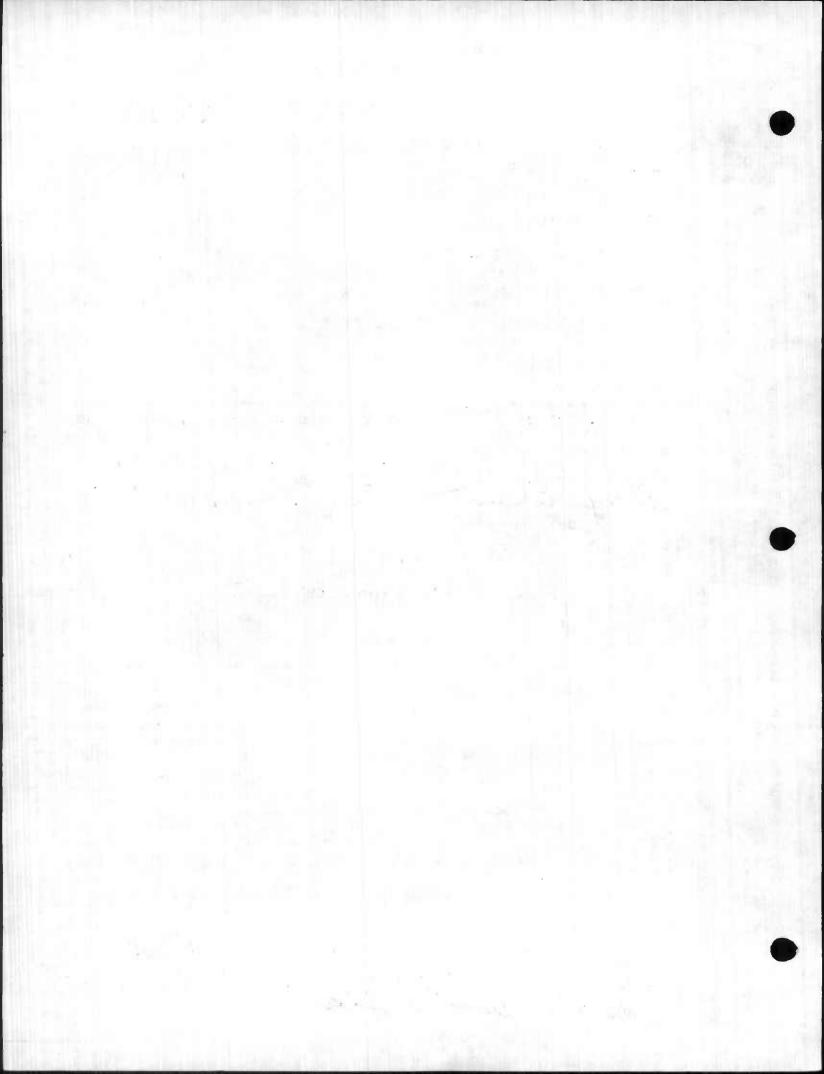
| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier edical (Check only one) 29c. License number 29g Dafe signed (Month, Day, Year) 29b. Signeture and fittle of certifier 20313 19.m MD 30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) David A. Rapko

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State Registrar

31. Dete filed (Month, Dey, Year) AUG 2 5 1

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State of Maryland / Department of Health and Mental Hygiene

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	Examir	ner	4a. Facility Name (If not institution, g							ocation of Deat	h 4c. County	of Death			
i	Funerai				ALTIMOR	irthday) I	f Under 1 Y		LTIMO ler 24 Hrs. s Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign		
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	with with						10f. Zip Co				10g. Citizen of	Whet Coun	lty?		
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002	72 hours after death with the Maryland "natural", or items 23a or 28a-f show solical Exacther must be retified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No Specify:					Specify	Bla	ick		
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altimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice		King	Mem 22. N	orla ame and A	l Par	K 8	/27/99	Randa	llst	own, Md		
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	30 500		23a. Part1. Enter the disease, or conshock, or heart feilure. List only	nplications that car	used the death. Do	430 not enter th	O Wa	bash dying, such	Ave, as cardiac	Balti or respiretory a	more M	d 2	Approximate Interval Between		
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0	the she	Physician	Part II. Other significant conditions	contributing to dea	th but not resulting i	n the unde	rlying caus	e given In Pe	rt I.	23b. Dld	tobacco use co	ntribute to	the cause of death?		
ď.									1 Yes 2 No 3 F		3 Prob	Probably 4 Unknow			
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Record	_ 0	se Completed								perfo	med?	ava	alleble prior to mpletion of cause		
	The law ate has t page 2 s									10.	Van (NOM)a		death?		
Viita			25. Was case referred to medical					26 Ple	nce of Death	n (Check only o			Yes No		
_	Physiclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 ER/O	utpatient	3□ DOA	Other			denca 6 □Oth	er (Specify	()		
n of	ding Ph h. After th funeral		27. Manner of Deeth 1 Natural 5 Pending	28a. Date of (Month)		Time of Injury	28c.	Injury at Work?		28d. Describe I	how injury occur	red			
SIO	Attending or death. ector: After by the fune	edicai Certification:	2 Accident investigation 2 Suicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 1 Yes 2 No 28e. Place of Injury - At home, tarm, street, factory, office City or Town, Stete)												
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Physician /Medical Examiner

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Physician

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Completed

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Funeral

Director

al Hypene. other than "natural", or leans 23s or 28s-f show went, the Medical Examiner must be notified at

2 should be filled within 72 hours after and Mental Hygiene. Is marked other than "natural", or Its

Baltimore, Maryland 21215-0020

physician and s the burial-trans as 980 for signed by the a peeu has certificate funeral director, this

certificate be exec Box 68760, P.0. Division of Vital death. i or Attend after death Director: A To the Hospital within 24 hours a To the Funeral C • Hospital completely

Medical

State Registrar

Examiner Physician/Medical 2 Completed Be 0 Certification:

27. Manner of Death

Netural

2 Accident

3 Suicide

29e. Certifier (Check only one)

29b. Signature a

30. Name and

Burns

4 | Homicide

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

[In the pical Examiner On the basis of examination and/or investigation in my opinion, death accurred at the time. On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

D0053607

August 15, 1999

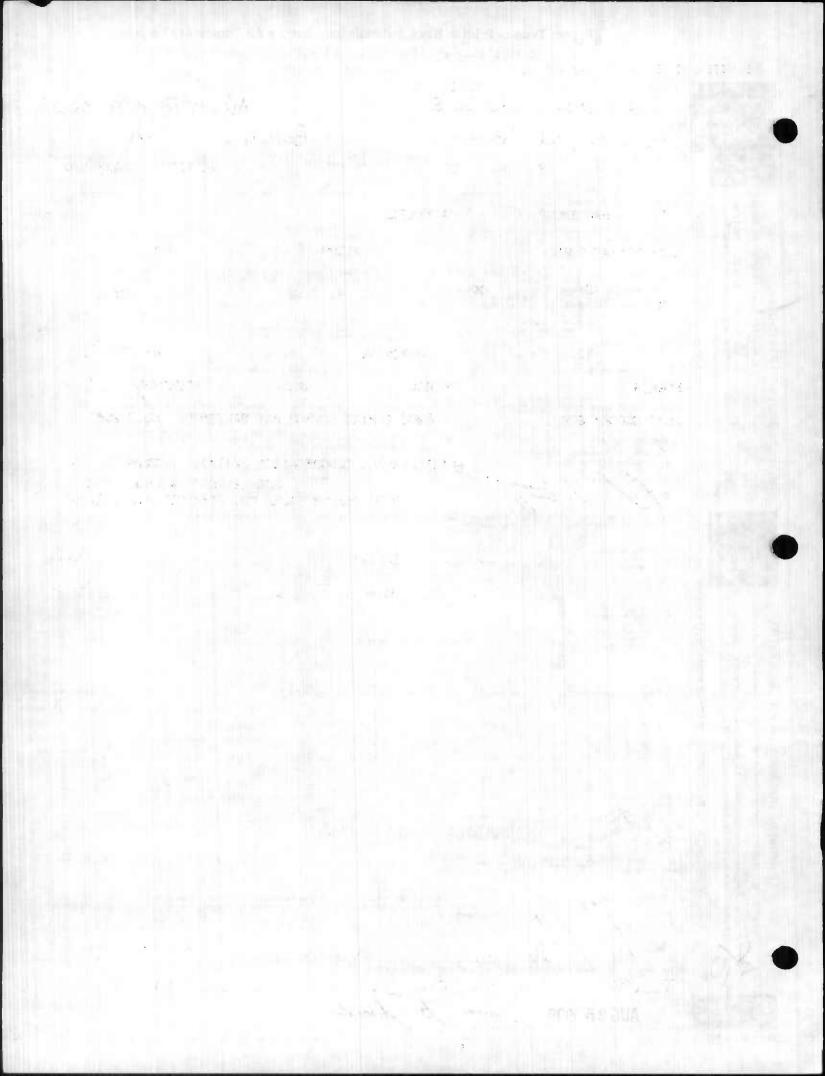
Tousan, MO

7505 Osler Drive 32. Registrer's Signature 31. Date filed (Month, Day, Year) AUG 2 5 1999

address of person who completed cause of deeth (item 23a) (Type, Print)

ho

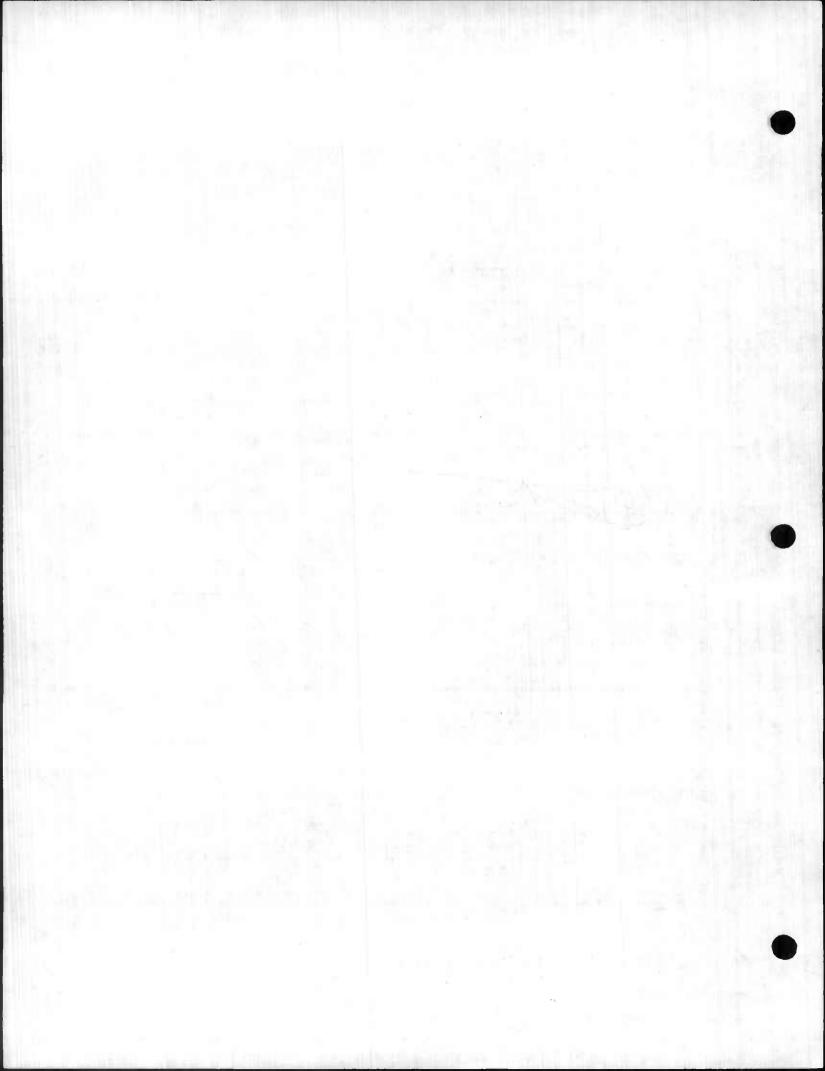
Suite 306.



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					e of Deat		110	g. No.				
rojojom	1. Decedent's Name (First, Middle, L.	ast)					2. Date of Deat Month	Day	Year	3. Time of Death		
ysician Aedical	MICHAEL	E.	MART	INO			August		1999	2:25 P		
aminer	4a Facility Name (If not institution, gr	ive street and number)			4b. City,	Town, or Le	ocation of Death	4c. County				
	North Arunde	el Hospital				Bur	nie	Ann	e A	rundel		
eral ctor	5. Social Security Number 6. 439-63-2569	Sex 7. Age (I	In yrs. last birti 56	hday) If Under Months	1 Year If Und Days Hour		8. Date of Birth (Month, Day, DEC . 14	Year) , 1942	9. Birthpl Court CALI	laca (State or Fore try) FORNIA		
_	Usual Residence of Decedent											
3 .	10a. State 10b. County	16	0c. City, Town	or Location					10	0d. Inside City Lin		
cto in	MARYLAND ANNE	i	MILLERSV	ILLE					1 Yes 2 2			
if Director	10e. Street and Number 505 CHALET DRIVE			10f. Zip	Code 21108		10	0g. Citizen of What Country? U.S.A.				
ioer must Funeral	11. Marital Status	12. Was Decedent Eve	er in U,S.	13. Was Decede	ent of Hispanic	Origin? (Sp	ecify Yes or No-					
by a	1 Never Married 2K Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		9750 / A. 1560	ify Cuban, Mexic		B.F. M.		14. Race - American Indian, Black, White, etc. Specity: WHITE b. Kind of Business/Industry CABLE TV INDUSTRY iden Sumame) SANCHEZ ity or Town, State, Zip Code) 1, MD. 21108			
completed	15. Decedent's E	Education	16a.	Decedent's Usual (Give kind of work	l Occupation	net of work	ina	16b. Kind of Business/Industry				
a od	Elementary/Secondary (0-12)	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			e retired)	OSI DI WOIR	m/g					
5						OITAL	1	CABLE	TV IN	NDUSTRY		
Be (17. Father's Name (First, Middle, Las	st)			18. Mo	ther's Nam	e (First, Middle, A	Maiden Surname)				
To T	LEO	M	ARTINO			HELEN		S	ANCHE	Z		
tracm	19a. Informant's Name/Relationship VERNA D. MARTINO											
-eqto	20a. Method of Disposition		20b. Place of	Disposition (Nam	a of	!	Date 2	20c. Location	- City or To	wn. State		
8	1 ☐ Burial 2 ☐ Cremation 3 [y, crematory or of			/24/99					
any injury or ance.	4 Donation 5 Other (Spec		CHESAP	EAKE CRE				STEVEN				
P 20	21. Signature of Fullert Service Licentees 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,											
3 a	1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061											
ian	23a. Part I. Editor the disease, or con shock of bleat tellers. List only	mplications that caused the y one cause on each line.	e death. Do n	ot entar the mode	of dying, such	as cardiac	or raspiratory arra	st,	1	Approximata Interval Between Onset and Deat		
ical	L											
	i immediata Cause (I-inal	N AA	9-	2 1	0		0		1			
ner	Immediata Cause (Final disease or condition resulting in death)		torg		Ivojav	F	aclen	ne	1	- Hi.		
	disease or condition	Du	e to (or as a c	gem (Ivojav	F	aclen	ue	 	130		
ě	disease or condition resulting in death)	sep	e to (or as a c	consequence of):	Ivgar	F	aclen	ue				
ě	disease or condition resulting in death)	sep	e to (or as a c					ue				
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he burletransit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sejan	e to (or as a co	consequence of):								
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sadie Anne McGraw 1.4090 Maust /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 5. Social Security Number R San Baltimore Roseda HOSPital Cen
7. Age (In yrs. last birthday) Center If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year)
July 2, 1942 Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2ØF Hours 57 220-36-8300 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show be notified at tXXes 2□No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a 5815 Plumer Avenue 21206 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Merried Maryland 21215-0020 b 1 Yes 2X No Specify: Specify: White ğ 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Medical Records Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 2 Charles F. Pfister Rose E. Phillips 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: if Item 27 is a any injury or other trau Mr. Kevin P. McGraw / Son Same as item 10e. altimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery 8/23/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Leonard J. Ruck, Inc. Funeral Home 21. Signature of Fungful Service Licensee Timothy Harman 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallum. List only one cause on each line. Physician Wedical Immediate Cause (Final disease or condition resulting in death) 4ears Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician the buria P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 8 080 ned by the at detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 200 Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Yes 2 No Certification: To 12 Inpatient 2 ER/Outpetient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 1X Netural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier completely (Check only within 2 To the 29b. Signature and talk of certific 29c. License number 29d. Date signed (Month, Day, Year) Mal 08-19-1999 6642

State Registrar

AUG 2 5 1999

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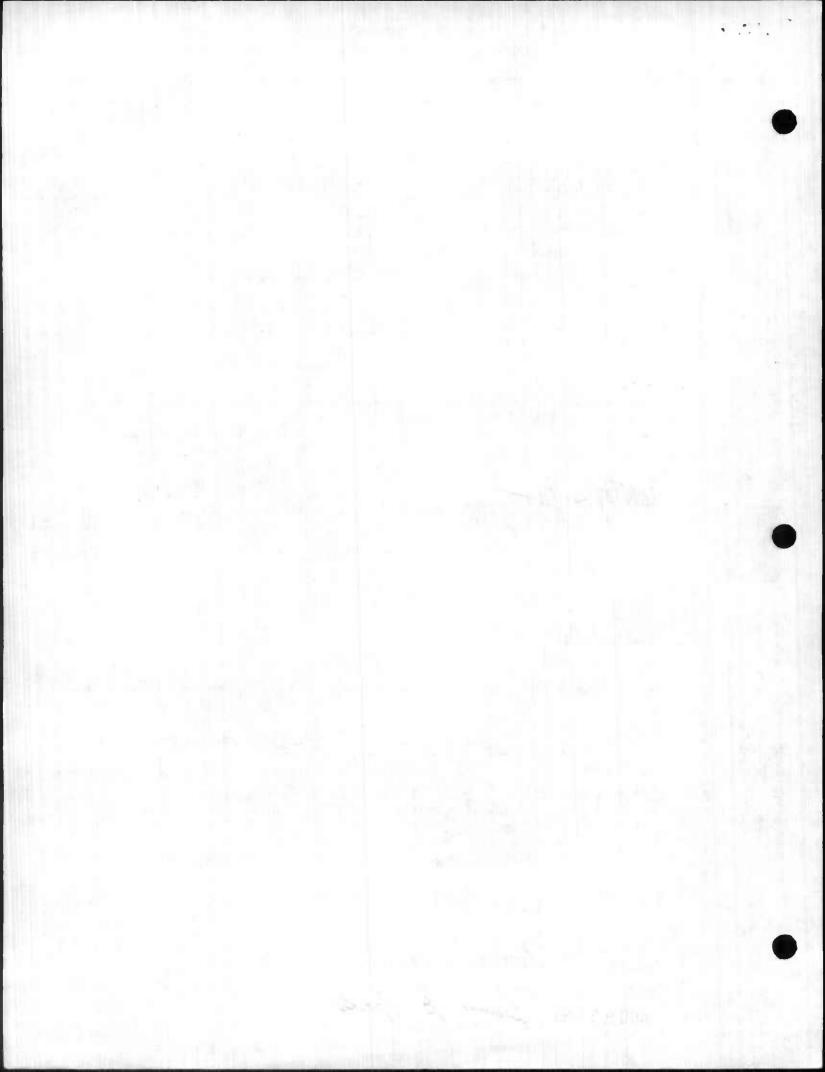
31. Date filed (Month, Day, Year)

9000 Franklin Square Drive Baltimore, MD. 21237 32. Registrar's Signature

0001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

o pez



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month August 21, 1999 **Physician** Theresa R. Nadolny 9:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing and Rehabilitation Center Baltimore N/A f Undar 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Ye 8/2/1928 Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 X F Months Hours 220-24-0246 Director Maryland **Usual Residence of Decedent** 10a Stata 10c. City. Town or Location 10h County 10d, Inside City Limits ? Is marked other than "natural", or items 22e or 28e-f show treumstic event, the Medical Exeminer must be notified at MD Baltimore Baltimore 1 Yas 2 XNo Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3 Propeller Drive 21220 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiens. Important: if them 27 is marked other than "natural", or any Injury or other trauments. 1 Yas 2 No If Yes, Give Year or Datas: 1 Never Merried 2 Married Specify: White 1 Yas 2 No Specify: þ 3 Widowed 4 Provorced Completed 15. Decedent's Education (Specify only highast grada completed) 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Overlea Caterers 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 96 Alexander Campoli Julia Furini 19b. Mailing Addrasa (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Dolores Lurz 2249 Firethorn Road Baltimore, Maryland 21220 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata Oaklawn Cemetery 8/25/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral \$4 22. Nama and Addrass of Fecility John C. Miller Inc. vice Licensee 6415 Belair Road Baltimore, Maryland 21206 Part Enter the sa, or complications that odused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear down. List only one cause or each line. 23a. Parl+. Enter Approximate Interval Betw Onset and Death **Physician** /Medical Immediata Causa (Finat diseasa or condition resulting in death) METASTATIC LUNCY CANCER Examiner Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificate has 210No 1 Yas 2 No 1 Yas To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; Be 25. Was casa referred to medical 26. Placa of Death (Check only one) Hospitat: Other: 4 Aursing Homa 5 Rasidenca 8 Othar (Specify) 1 Yes 2010 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date and placa, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Pay, Year) lesole D52228

State Registrar

INLKUMAR

31. Date filed (Month, Day, Year)

AUG 2 5 1999

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Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

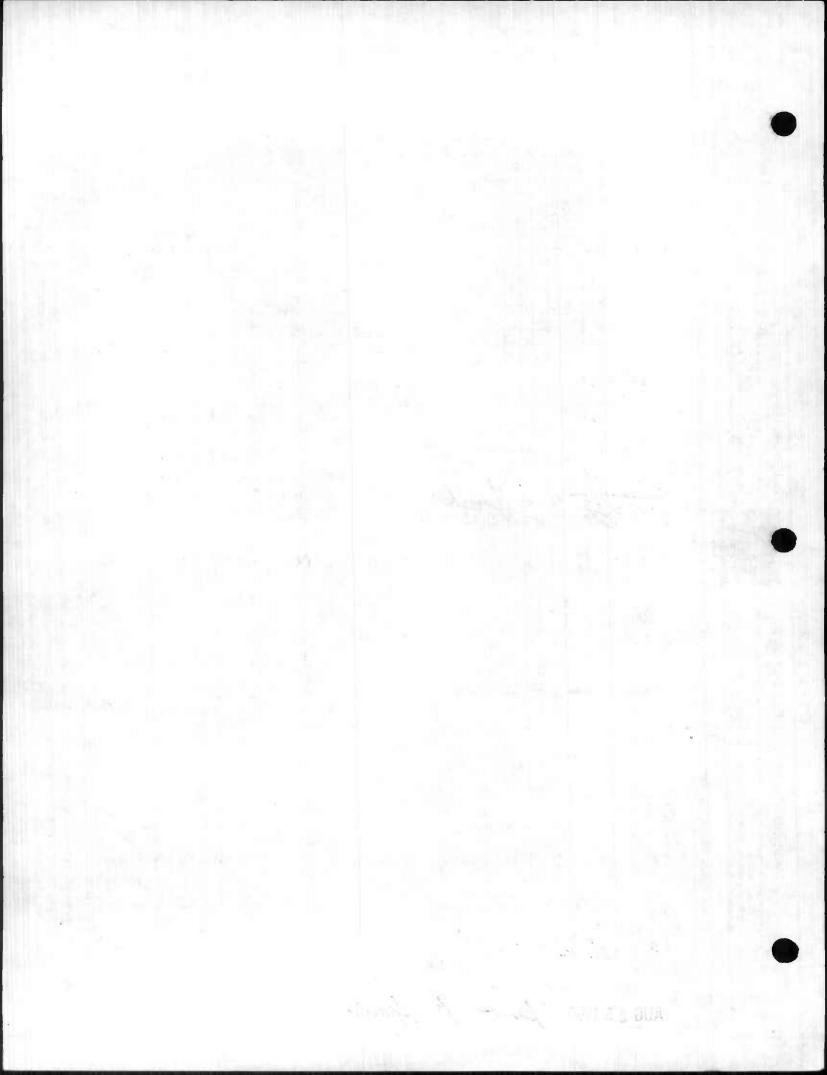
3007 ENORTHERN PRWY BALTIMORE

21214

30 Nama and add out of person who completed causa of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature

BHAZD MA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death AUGUST 01.20A.M DRIS LOUISE OBIE 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE A.A. HEALTH MARINER COUNTY If Undar 24 Hrs. If Undar 1 Yaar Birthpleca (Stata of Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1□M 2**%**F 220-14-7454 Yrs. JAN. 25, 1924 MARYLAND Usual Rasidance of Decedent 10a, Steta 10b. County 10c. City, Town or Location 10d. inslda City Limits 1 ¥Yas 2 No BALTIMORE MARYLAND 10e. Straat and Number 10f. Zip Coda 10g. Citlzan of What Country? AVENUE 21225 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 K No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Marriad Specify: BLACK 1 ☐ Yas 2 X No Specify: 3 50 Widowad 4 □ Divorced 15. Decedant's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry (Spacify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 12TH GRADE FOOD BALTIMORE CITY SERVICE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) STANLEY COOK WEBSTER GRACE I. 19e. informent's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) (NIECE) DORIS BURRIS 437 SWALES AVE., BALTIMORE, MARYLAND 21885 20b. Placa of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Locetion - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata BALTIMORE NATIONAL CEMETROY-25-99 BALTIMORE, MARYLAND 4 Donation 5 ☐ Othar (Specify) 21. Signature of Funaval Sarvica Licare 22. Nama and Addrass of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BACTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. intarval Batween CARCINOMA OF GALL BLADDER immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaesa or injury that initiated events resulting in death) Last ERTENSION. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24e. Was an autopsy completion of cause of death? 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida

Time Certifying Phyalcian: To tha best of my knowledge, deeth occurred et the tima, deta and place, and dua to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and dua to the causa(s) and manner stated.

29d. Data signad (Month, Day, Year)

The law requiras that the death certificate be executed Box 68760. P.O. Records, should be d Division of Vital or Attending Physician: After death. after death

Examiner Physician/Medical by Completed page 2 Be Certification: To funeral in by tha

Physician

/Medical

Examiner

Funeral

Director

"natural", or itema 23a or 28a-f an

traumatic event, the Medical

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Physician

2 should be filed with and Mental Hygiene.

Director

Completed by Funeral

Be

State Registrar

Medical

29a. Cartifian

(Check only one)

31. Data filad (Month, Dey, Year) AUG 25 1999

29b. Signature and titla of cartifier .

32 Registrar's Signature

MARYLAND- 21225.

DHMH 16 Rev 6/95

To the Hospital within 24 hours a To the Funerel E Hospital

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Deeth 3. Tima of Death 10:11 Am Month ANNA PAXTON 4c. County of Death 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death BALTIMORE BON SECOURS HOSPITAL If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth Hours Min. Manth. Day. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Yrs. Birthplaca (Stata or Foreign 1□M 2XF 219-42-6258 Usual Residence of Decedent 06,1 10a. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits Maryland 1 Yes 2 No more 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2026 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian 11. Marital Stetus Bleck, White, atc. 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify: 3 Widowed 4 □ Divorced American TITTO 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) College (1-4or 5+) Elementary/Secondary (0-12) ex 18 Mothar's Name (First, Middla, Maiden Sumama 17. Fathar's Nema (First, Middle, Last) (niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greens ve. 20b. Plece of Disposition (Nama of camatary, cramatory or other plece, /Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from State ore 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nema and Addrass of Facility Toseph L. Rus Home Bal 5 Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or thing failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediata Causa (Final ATHEROSCLEROMIC CARDIO VASCULAR DISEASE disaasa or condition rasulting in daath) Due to (or es e consequence of) Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as e consaquence ot): that initiated avants rasulting in daath) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown HYPERTENSION 24b. Ware autopsy tindinga available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DIABETES MELLITUS PARKINSONS DISEASE . UROSEPSIS 1 Yas 2 HO 1 Yas 2 No 25. Wes case reterred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28b. Tima ot 28d. Dascribe how injury occurred 5 Panding 1 Yes 2 No 2 Accident 28a. Placa of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicida 4 Homicida

attending physicien and for use as the buriel-transit The law requires that the death certificate be executed funeral

Physician

/Medical

Examiner

Funeral

Director

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Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours effer death with the Meryland nant of Health and Mental Hygiena. Int: If flem 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

marked other than "natural", or items 23a or immit event, the Medical Examiner must be a

Important: If fi

Physician /Medical

Examiner

Physician/Medical Examiner

Completed by

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Certification: To

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permit. Page Department of

Division of Vital Records, P.O. Box 68760, or Attanding Physician: s efter death. 6

24 hours eftar Funeral Dire Hospital To the Fund

To the Within 2

State Registrar

THOMAS 5. 31. Data tiled (Month, Day, Year) AUG 2 5 1999

29b. Signatura and titla of cartitian

(Check only one)

30. Name and eddrasa of person who completed causa of daath (Item 23e) (Type, Print) MILLER

Thullen

BON 32 Registrar's Signatura

1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated.

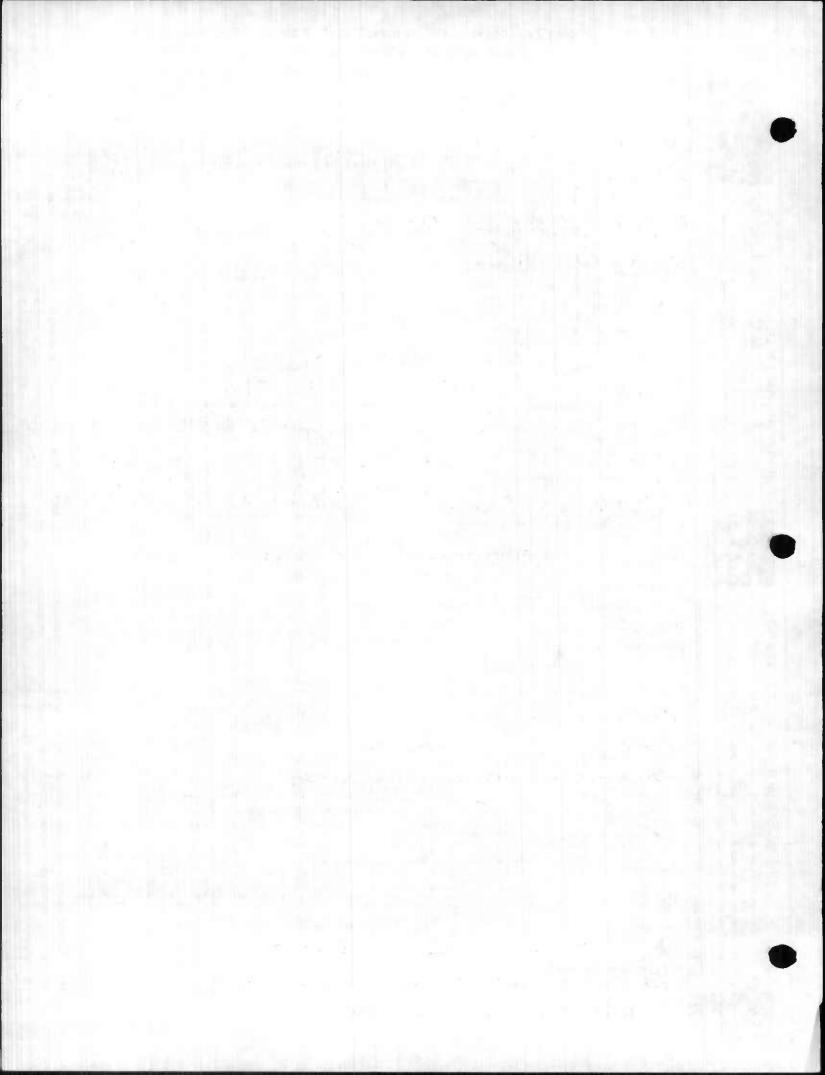
29c. Licansa number

D30272

SECOURS HOSPITAL BALTIMOZE, MD.

29d. Date signed (Month, Day, Year)

AUG 23



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** 11:03 10 August Jake C, Price 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. Hours Min. if Under 1 Year | Months | Deys 5 Social Security Number 7. Aga (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months 1⊋M 2□F 214-86-6161 33 Director 12-15-65 MD Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Haalth and Mental Hygiena. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mass has natified. 10c. City. Town or Location 10e Stete 10h Counts 10d. Inside City Limits MD NA Baltimore MGYes 2□ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2725 Pelham Street 21213 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1□ Nevar Married 2□ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 10th Grade Banquet Houseman Omni Hotel 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Jake Price Mamie Jones 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 21213 19e. Informent's Name/Reletionship (Type, Print) 2725 Pelham Avenue Baltimore, Maryland Sarah Price 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Voshell Mem. Gardens 08-28+99 Dundalk, MD 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Sarvice Licensee WM.C.March FH 1101 E. North Avenue 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner Shock attending physician and for usa as the burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immadiete ceuse. Enter Underlying Ceuse (Diseese or injury that initialed events rasulting in death) Last VRICE Take C. Division of Vital Records, P.O. Box 68760, an Cyla Physician/Medical Due to (or es e consequence of): signed by the a d be datached f 23b. Did tobacco use contributa to the cause of death? Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? s cartificate has to director, paga 2 s 1 Yes 2 No 1 □ Yes 2 □ No Hospital or Attending Physician: 25. Wes cese referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manyrer of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident aftar daatl 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours aftar da To the Funerel Directo complataly filled in by the 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and dua to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifiar 29c. Licansa number m. 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 860 Waser

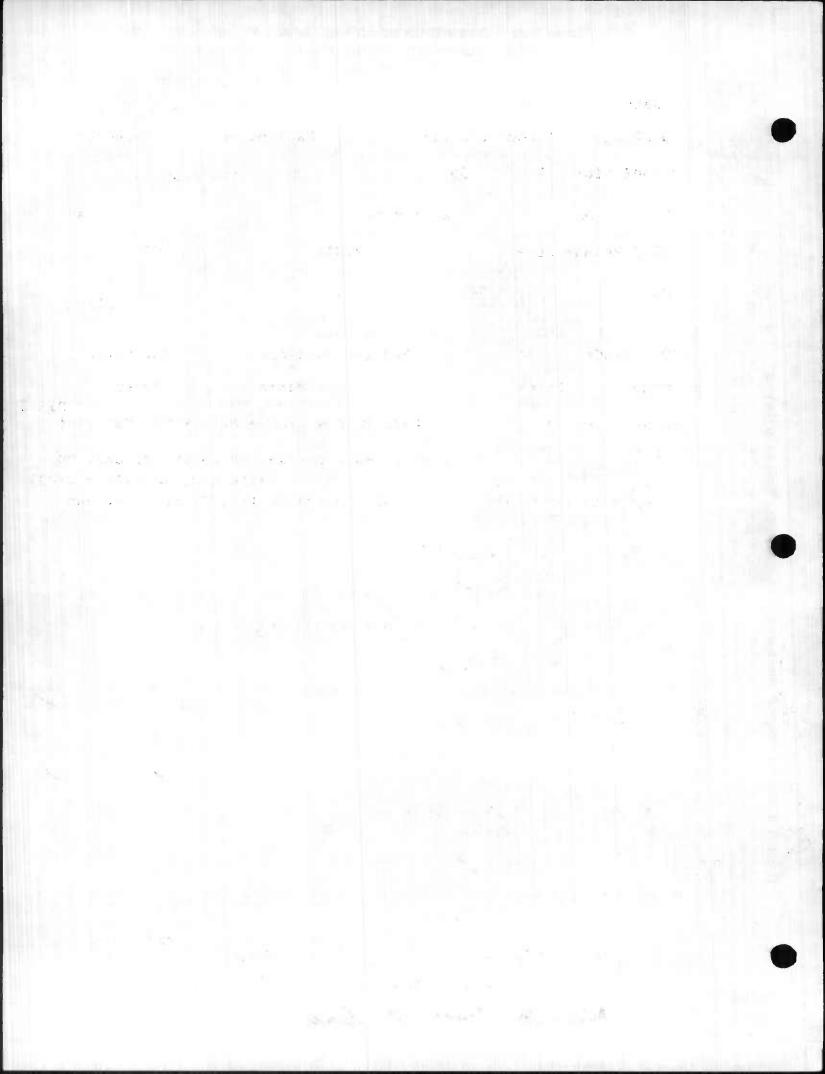
DHMH 16 Rev 6/95

State

Registrar

31. Date filad (Month, Day, Year)

AUG25



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 3:15 A.M AUGUST ANNIE /Medical 4b. City, Town, or Location of Deeth 4a Fscility Name (If not institution, give street end number) Examiner BALTIMORE ELDER C'ARE TON MANOR GENESIS 7. Age (In yrs. tf Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex lest birthday) **Funeral** 1 ■ M 2 X F Deys MARCH 14, 1906 NORTH CAROLINA Yrs Director Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 77 is marked other than "natural", or itema 23a or 28a-f show traumatic evant, the Modical Examiner must be notined at 1 Yes 2 No Funeral Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number USA. Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 1□ Yes 2 No Specify: BLACK Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED HOUSE KEEPER 6 THGRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be should be find Mental H (MN-UNKNOWN) ANDREW end ! 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 Department of Health e Important: If item 27 is VERNON J. PEELE BRUBAR COURT, APT. 2A BALTI MORE, HD. J/207 20c. Location - City or Town, State SON altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 12 Burial 2 Cremation 3 Removal from Stete ò DRUID RIDGE CEMETER 8-23-99 BALTIHORE, MARYLAND any injury 4 ☐ Donation 5 ☐ Other (Specify) BROWN JR. FUNERAL HOME 22. Name and Address of Fecility Funeral Service Licansee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medicai Metastetic honks Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the bunal-trensit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificata be exed P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown town on Division of Vital Records. 2 8 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of deeth? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medicat examiner? Be 26. Piece of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury at Work? 5 Pending investigation Hospital or Attanding Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 ACertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edica 29a. Certifier completaly (Check only one) within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier 20,1999 D-405 Wilkens Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3370

DR. OCHANEY

Rathmore

Registrar

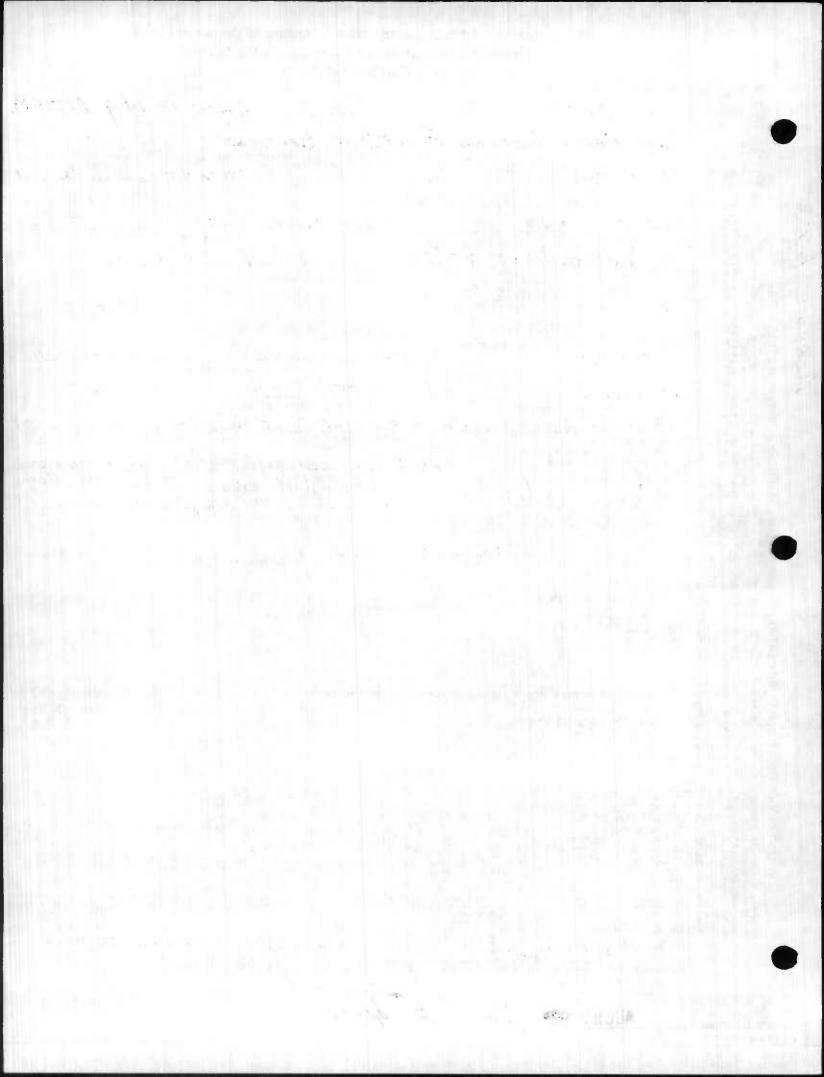
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AUG 25 1999

OCHANEY

Rathmory MD 32. Registrar's Signature

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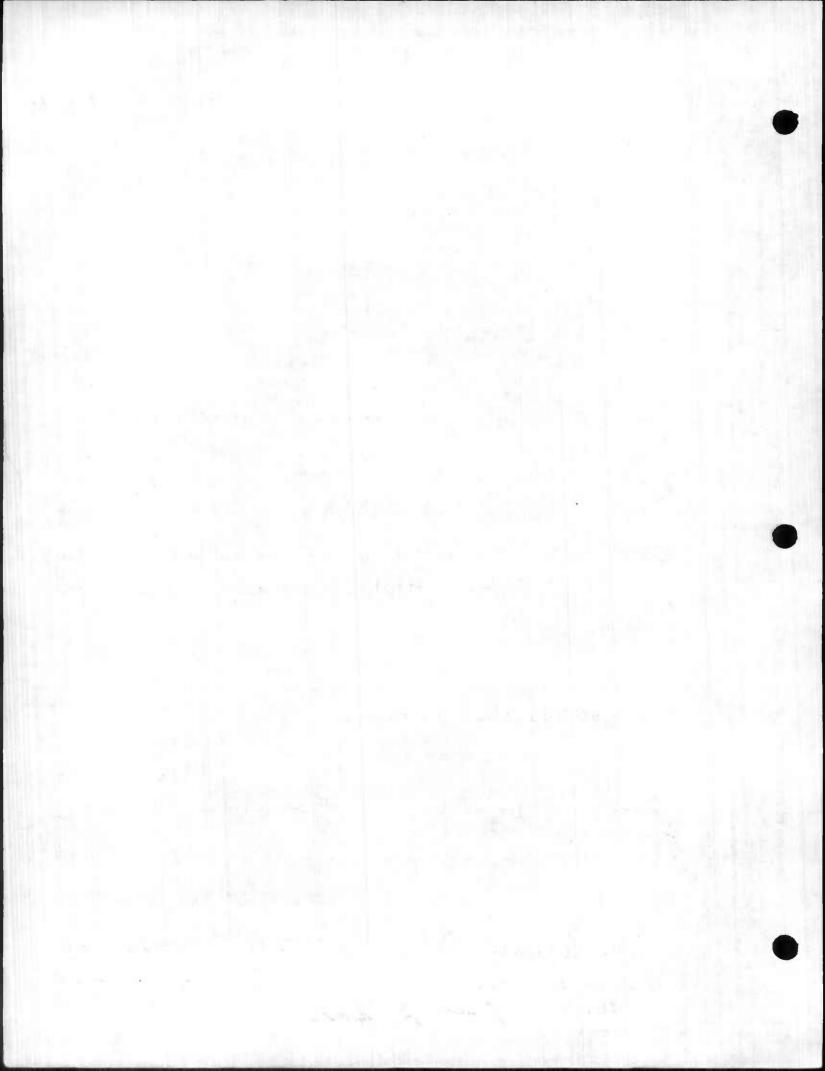


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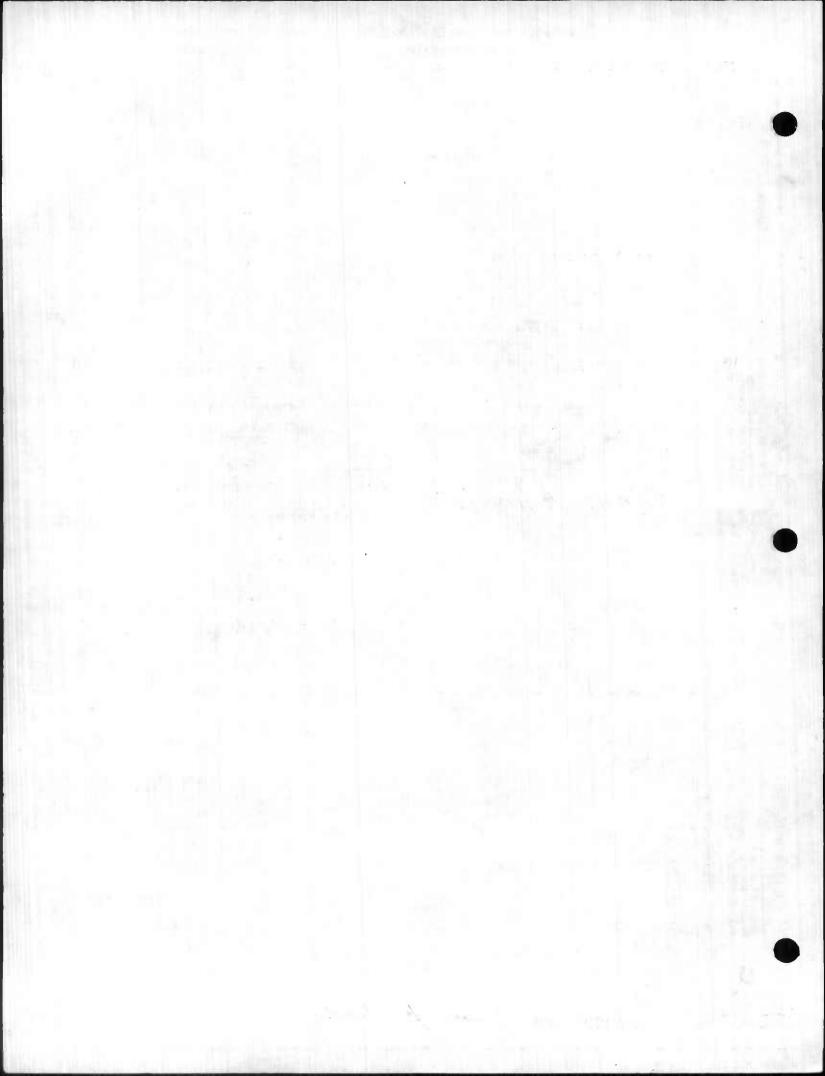
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	ician dical	Decedent's Neme (First, Middle BEREL	1. Decedent's Neme (First, Middle, Last) BEREL				PER	2. Dete of Deal					
	niner	4a Facility Name (If not institution BRIGHTWOOD MI	JOME		4b. City, Town, o	Location of Death							
Funer	al	5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday	If Under 1 Year Months Days		s. 8. Dete of Birth					
Direct		150-07-6025 Usuel Residence of Decedent	1 ⊠ M 2□F		81 Yrs.	Wioralis Days	Tiouis III		2, 1918	RUSSI	Α		
yland		10a. Stete 10b. County		10c. City, Town or Location						10d. Inside City Li	imits		
Serf al	Director	MD N/A		BAI	TIMOR	E				1 ☑ Yes 2 ☐	No		
with the		10e. Street and Number 2500 W. BELVI	EDERE AVENI	JE #83	18	10f. Zip Code	21215	_1		nat Country?			
death ms 23	Funeral	11. Meritel Stetus	12. Wes Deced	ent Ever in U		Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No-	14. Race				
d 21215-0020 filed within 72 hours after death with the Meryland Hygiene. ther then "neturel", or flems 23e or 28e-f show ant, over lead or I seemine must be notified at	by Fu	1 Never Married 2 Men 3 XWidowed 4 Divorced	ied 1 ☐ Yes 2	XNo		1 Yes 2 No	Specify:	noen, etc.)	Specify:	WHITE			
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nd 212. If Hygiene. other than	Be Co	17. Fether's Neme (First, Middle,	Last)		OWINE	iK	18. Mother's N	eme (First, Middle, I		Ac. County of Death BALTIMORE 9. Birthplace (State or Foreign Country) 1918 10d. Inside City Limits 1 M Yes 2 No Citizen of What Country? J.S.A. 14. Race - American Indian, Bleck, White, etc. Specify: WHITE Kind of Business/Industry CONFECTIONERY STORE en Sumeme) (UNKNOWN) yor Town, State, Zip Code) MILLS, MD 21117 Location - City or Town, State ROSEDALE, MD ON & BROS., INC.			
Maryiand 21215-0020 d 2 should be filed within 72 hours aff h and Mental Hygiene. 7 is marked other than "naturel", or treumstic evant, or a Medical Exerci-	ToE	MICHAEL				PER	BETH	NKNOWN)					
		19e. Informent's Neme/Relations PENNY PATRIC		ER.	7110								
		20a. Method of Disposition		20b. F	Mace of Disp	osition (Name of emetory or other ple							
		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate									
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VA		Lacin 1	U- Mille	3 1	10	- DE	1742	1	8-2	2-99			
110	0	30. Neme and address of person	who completed cause	of death (Item	23a) (Type	Print) = 3 00	R.	Himor	a Mil	2120	8		
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ORIGINAL



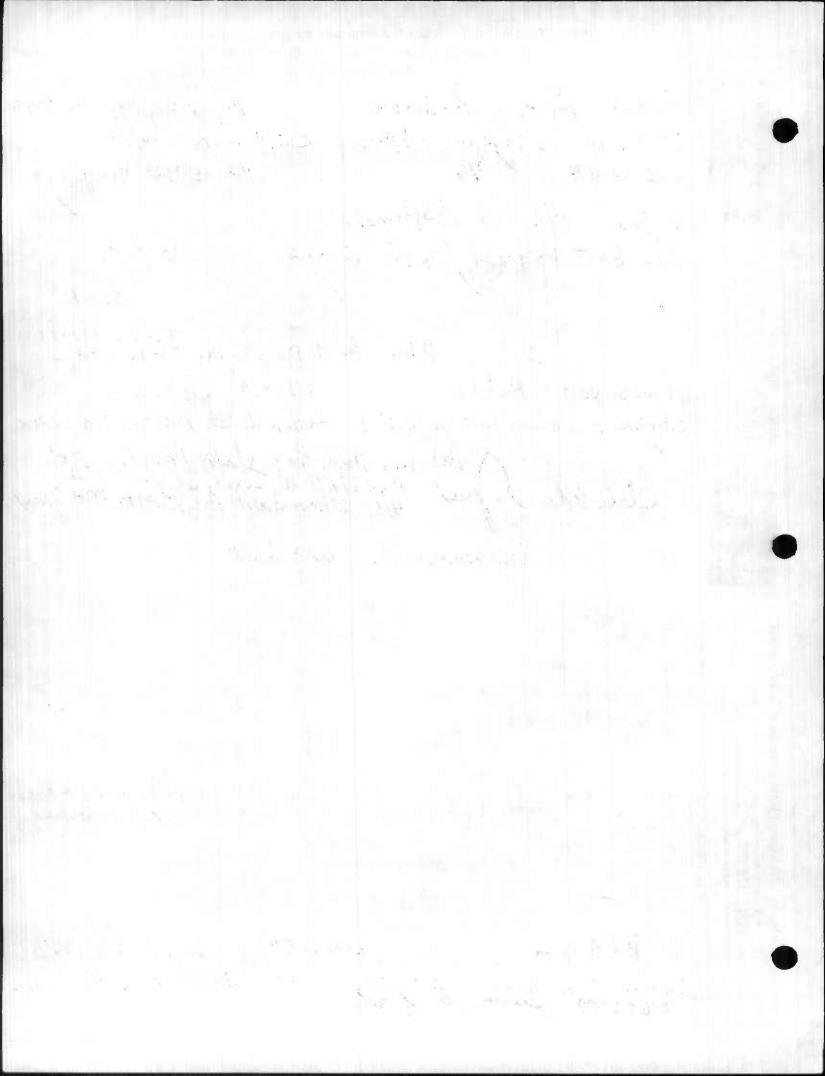
	_	1. Decedent's Nam	ne (First, Middle	ALC: NO			ertificat			2. Date of D			Vers	3. Time of Death					
Physicia Medic/		Philip Richman 4a Facility Name (If not institution, give street and number) 4b. City, Tor								Augus	_	6 1	Year 999	0418					
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The M	Director	10e. Street and Nu					10f. Zie	Code			100 0	Citizen of What Country?							
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88122	1	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 2140										11							
		23a. Part Enter t	the disease, order failure. List	complications that	caused the c	death. De not e	nter the mod	le of dyin	g, such as cardiac	or respiratory	arrest,	, 110	2140	Approximate					
Physician	H					- 1													
/Medical Examiner		Immediate Cause disease or condition	n	a LONGESTIVE HEART FAILURE							1		YRS						
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yalci is cer direc	0	examiner? 1 ☐ Yes 2 ☒	No	Hospital: 1	Inpatient	2 ER/Outpatio	ent 3 D'DC	Oth Oth	er	lome 5 Re		6 Oth	er (Specif	y)					
nding Ph ath. r: After thi		27. Manner of Deat 1 2 Natural 2 Accident	h 5 Pending investig	28a. Date (Mo	e of Injury onth, Day Yea						cribe how injury occurred								
or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determine	ned 286. Plac	ce of Injury - Adding, etc. (Sp	At home, farm, s	treet, factor	y, office		28f. Location City or To	(Street a	and Numb ite)	er or Rura	al Route Number,					
To the Hospital or Attending Physicien: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	_	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: On the	ne best of my besis of exam inner stated.	knowledge, dea nination and/or i	th occurred nvestigation	at the tin , in my o	ne, date and place pinion, death occu	, and due to the	e cause(o, date a	s) and ma nd place,	anner as si and due to	tated. the cause(s)					
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Registra	r		ALIG 95	4000	D. LAND	w M	10	THE KI											



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Deeth August 15 **Physician** edmono /Medical 4b. City Town, or Location of Deeth 4c. County of De 4a Facility Neme (If not institution, give street and number) Examiner 6. Sex If Under 1 Year Months Deys 106 8. Dete of Birth Month, Day, age (Ip yrs. last birthday) If Under 24 Hrs 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2 Min 223-22-5099 Hours Director Usual Residence of Decedent with the Maryland 10a State 10b. County C)ty, Town or Location 10d. Inside ty Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 PYes 2 No Director MARY And more 10f. Zip Code 10g. Citizen of What Country? 212 1805 Funeral deeth Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca American Indian. 11. Marital Status if Yes, specify Black, White, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or first any injury or other traumatic avant man 1 Yes 1 Never Married 2 ☐ Married 1□ Yes 2DNo Ac Baltimore, Maryland 21215-0020 Specify þ Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hopkins Elementery/Secondary (0-12) College (1-4or 5+) Mursine amin, HSS H05 18. Mother's Name (Fi st. Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٧ ohn 1005e Velt City or Town, State, Zip Code) 19b. Meiling Address (Street and Number or Rural Route Number, Informant's Name/Relationship (Type, Print) nd Stephanie 20a. Merbod of Disposition 05 2/2/3 20b. Piace of Disposition (Name of 20c 1 Buriel 2 Cremation 3 Removal from 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 5 8 23a. Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause on Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner buniel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca of): pue Division of Vital Records. P.O. Box 68760. physician certificate be Physician/Medical the Due to (or es e consequence of): 88 950 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Aq 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy peen completion of cause of death? has page 2 2 NO 1 ☐ Yes 2 ☐ No certificete 1 Yes Attending Physician: funeral director. MARIS A MERCY 25. Was case referred to medical 26. Plece of Death (Check only one) STE 11 Be examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOSPICE 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Menmer of Death 28b. Time of Injury at Work? After Injury 1 Natural 5 Pending 1 Yes investigation Accident ne Hospital or Attend n 24 hours after deeth ne Funeral Director; A 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier → Confifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the Within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type,

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GERTRUDE M. RASPA 1:35am /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE ARUNDEL +OSPITAL GIEN OUNT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 6, 9. Birthplece (State or Foreign **Funeral** Days Hours 1 M ACKE MARYLAND Yrs. Director 212-18-9585 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1□ Yes 2√No MARYLAND ANNE ARUNDEL Director GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 7807 LEYMAR ROAD 21060 UNITED STATES ітеть 23в Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ² Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 5 by 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING MANUFACTURING Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked othy any liquy or other traumatic event soice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ PETER NOVAK MARY SKOWRONSKI 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS RASPA/SON 7807 LEYMAR ROAD GLEN BURNIE, MD 21060 20a. Method of Disposition T Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State AUG. 27, place) HOLY ROSARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 1999 DUNDALK, MARYLAND 21. Signature of Funeral Service Licenses 22. Name end Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician STAGE RENAL DISEASE /Medical Immediate Cause (Finai disease or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): and Box 68760. physician Physician/Medicai the Due to (or as a consequence of): 88 ettending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No this certificate 1 Yes WINO or Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Impatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident after death in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital • Funeral 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(s) end manner stated. Medicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

301 Hospital

32. Registrar's Signat

Glen Burnie mp. 2106/

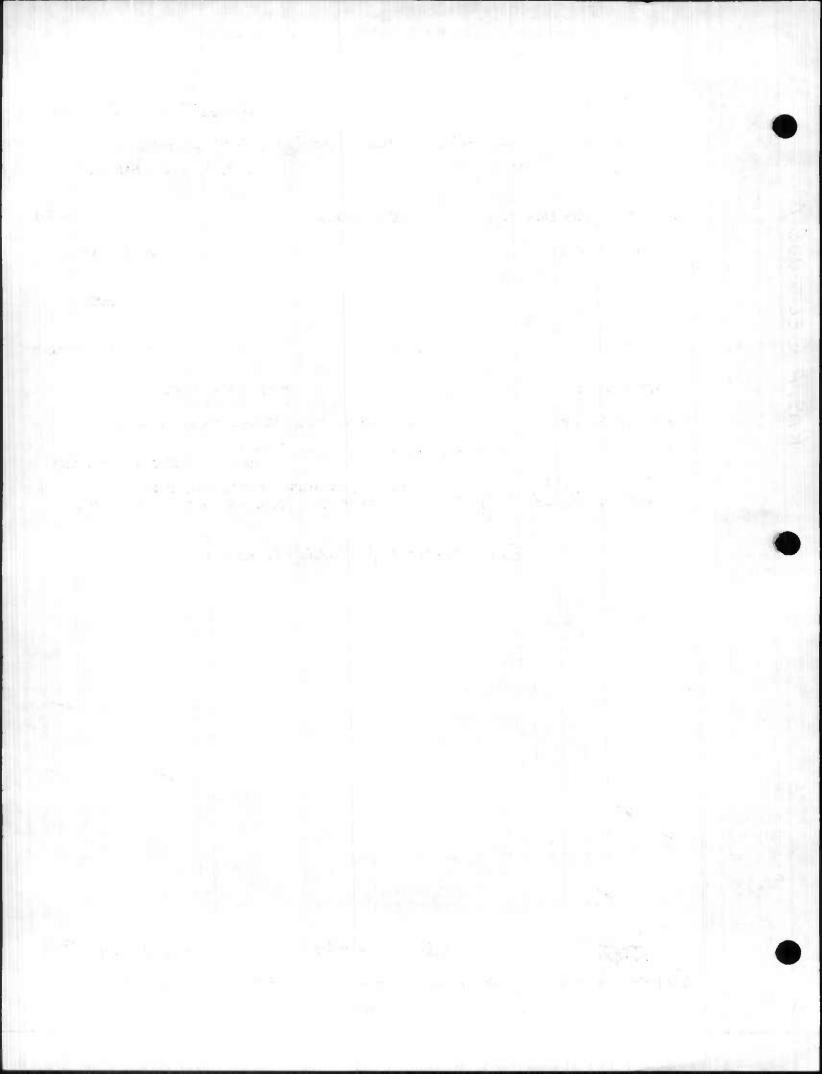
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Registrar

DHMH 16 Rev 6/95

State

31. Date file forth Date.



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Spence 9 year Month 22 Day Henry 21:05pm 4s Facility Neme (If not institution, live street and number) 4b. City, Town, or Location of Death 4c. County of Deeth UNION MEMORIAL HOSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Dete of Birth (Month, Day, Year) Days Months XIX M 2□ F Hours 76 246-16-5995 08 - 16 - 23NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore ₹ Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1705 E. 29th Street 21218 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes → No If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baltimore Museum Laborer of 7th Grade Art 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Enoch Spence Rosie Lowery 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxie Brockton 1705 East 29th Street Baltimore, MD. 21218 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removet from State 4 Donation 5 Other (Specify) Baltimore Cemetery 08-27-99 Baltimore, MD 22. Name end Address of Facility Baltimore, Maryland 21202 21. Signetère of Funerel Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx. Approximate Interval Between Onset and Deeth Immediate Cause (Final ancer Luno disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 3 Probably 4 Unknown 1 Yas 2 No pertension 24b. Were autopsy tindings available prior to ipercholostenotemia 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work?

Examiner the burial-transit pue The law requires that the death certificate be exec Physician/Medical signed by the attending p þ of Vital Records, Completed has page 2 this certificate or Attending Physician: Be Certification: To funeral After Division death. s after death the filled in by

within 24 hours a Hospital

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completely

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after than to Health and Mental Hygiens.

Interest of Health and Mental Hygiens.

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Department of Important: If

Physician /Medical

Examiner

Maryland 21215-0020

altimore,

25. Was case reterred to medicat examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 Neturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, tarm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifie (Check only one)

29c. License number

Ctn.

29d. Date signed (Month, Day, Year)

MD

21224

Baltimore, 1 2323 Orleans

State

Registrar

Dr. Nina Everett, 31. Dete filed (Moor), Veer) AUG 2 5 1999

30. Name and address of purpon who completed cause of death (Item 23a) (Type, Print)

29b. Signeture and title of certifier

Medical MD Matilda Koval 32. Registrar's Signature

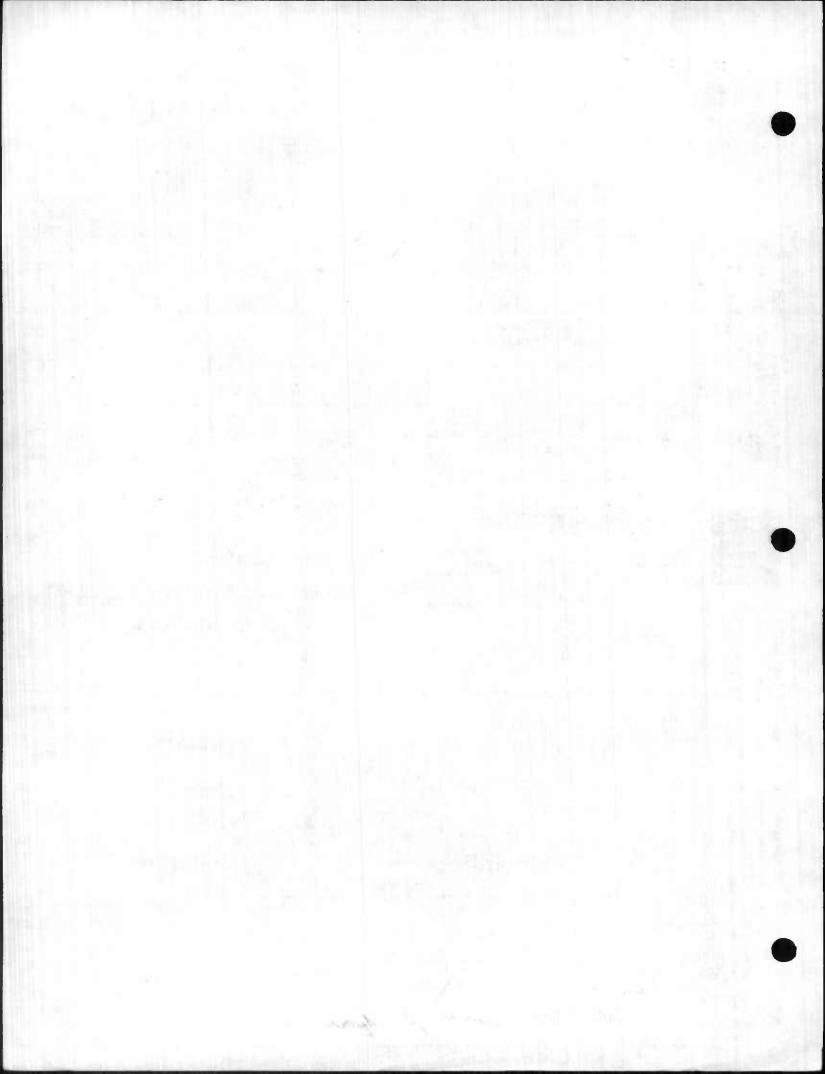
DHMH 16 Ray 6/95



1. Decedent's Neme (First, Middle, Last)		Certificate of Death				Reg. No. ath Day Ye	3. Time of Deeth		
HOWARD	C.		SAC		AUGUST	23, 1999			
4e Facility Neme (If not institution, give s				4b. City, Town, or			Deeth		
MANOR CARE ROLAN 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	BALTIMO		N/A	Birthplace (State or Foreign		
	M 2□ F 94	Yrs.	Months Days	Hours Min.	DEC. 2	0,1904	Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent 10a. Stete 10b. County	10c C	ty, Town or Loc	eation				10d, Inside City Limits		
		LTIMORE					1 ☑ Yes 2 ☐ No		
MD N/A 10e. Street and Number	10g. Citizen of Whe	at Country?							
2208½ SULGRAVE A	VENUE			21209		U.S.A.			
11. Merital Stetus 1 Never Married 2 Merried	Wes Decedent Ever in U Armed Forces? □ Yes 2 ☑ No	J,S. 13. V	Vas Decedent of Yes, specify Cub	tispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)		American indian, White, etc.		
3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		☐ Yes 2 No			Specify:	WHITE		
15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give i	ent's Usuat Occu and of work done O NOT use retire	pation during most of wo d)	rking	16b. Kind of Busin	ess/Industry		
Etementery/Secondary (0-12)	College (1-4or 5+)	OWNER				CONSTRU	CTION		
17. Father's Neme (First, Middle, Last)						Maiden Sumeme)			
JACOB		SACH		FANNY		0.	(UNKNOWN)		
19e. Informent's Neme/Relationship (Typ. MRS - FRAN SACHS - N				and Number or R E PIKESVI		or, City or Town, Sta 21209	ate, Zip Code)		
20a. Method of Disposition	20b.	Place of Dispos	sition (Name of setory or other pla	20)	Dete	20c. Location - Cit	y or Town, Stete		
1 Buriai 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State			CEMETERY	8_2/1_99	RETST	CERSTOWN, MD		
21. Signeture of Purperal Service License			Name and Addre	ess of Facility		Dec Silver	ROS., INC.		
ant	7	8	900 REIS				E, MD 21208		
23a. Pert1. Enter the disease, or compile shock, or heart failure. East only one	ations that caused the dea e cause on each line.	th. Do not ente	r the mode of dy	ng, such as cardia	c or respiretory ar	rest,	Approximate Interval Between Onset and Death		
Immediate Cause (Fine) disease or condition resulting in deeth)		ONGE	TIWE 1	tear ,	FAICURE		2-11 SMUTE		
	Due to (C An D	lo Mino	a Thu			246mc		
Sequentially list conditions, if any, leading to immediate	b. CARRIO MI GRATTING Due to (or as a consequence of):						, , ,		
cause. Enter Underlying Cause (Diseese or injury		GEN ER	-PERIOSC	LEPLOSIS	(by GANS				
that initiated events resulting in death) Last	Due to (d	or as a consequ	ence of):						
d.							.		
Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	derlying cause gi	ven in Pert I.	23b. Dld (lobacco una contri	buta to the cause of death?		
					10	Yaa 2□No 3	Probably 4 Unknown		
					24e Wes	en eutopsy 2	24b. Were eutopsy findings		
						rmed?	available prior to completion of cause of death?		
					101	res 2 No	1 ☐ Yes 2 ☐ No		
25. Was case referred to medical				26. Place of De	eth (Check only o		Since Control of		
	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Ot	her: 4 K Nursing I	lome 5 ☐ Resid	dence 6 Other	(Specify)		
examiner?		28b. Time of	28c. Inju	ry at rk?	28d. Describe t	now injury occurred			
1 Yes 2 No PAGE 15 NO	28a. Date of Injury (Month, Day Year)	Injury		IV-a GITH					
1 Yes 2 No PM 27. Manner of Deeth 1 SNeturel 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 1	Yes 2□No	28L Location (Street and Number	or Rural Route Number		
1 Yes 2 No PM 27. Manner of Deeth 1 Neturei 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Speci	Injury ome, farm, stre	M 1	Yes 2□No	28I. Location (S City or Tox		or Rural Route Number,		
1 Yes 2 No 27. Manner of Deeth 1 Neturei 2 No Pending investigation 3 Suicide 4 Homicide 29e. Certifier (Check only (Check only 2 Medical Examina)	(Month, Day Year) 28e. Place of Injury - At houlding, etc. (Specifican: To the best of my known. To the basis of examina	Injury come, farm, stre	M 1 cet, fectory, office	me, date and place	City or Too	vn, Stete) cause(s) and menn	er as stated.		
1 Yes 2 No 27. Manner of Deeth 1 Neturei 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29e. Certifier (Check only one)	(Month, Day Year) 28e. Place of Injury - At h building, etc. (Special clan: To the best of my known and the second secon	Injury come, farm, stre	M 1	me, date and place	o, end due to the	vn, Stete) cause(s) and menn date and plece, and	er as stated. If due to the ceuse(s)		
1 Yes 2 No 27. Manner of Deeth 1 Neturei 5 Pending investigation 3 Suicide 6 Could not be determined 29e. Certifier 1 Certifying Physic (Check only 2 Medical Examine)	(Month, Day Year) 28e. Place of Injury - At houlding, etc. (Specifican: To the best of my known. To the basis of examina	Injury come, farm, stre	M 1 Coefficient of the state of	me, date and place opinion, deeth occurse number	City or Tow	vn, Stete) cause(s) and menndate and plece, and 29d. Date signed (I	er as stated. If due to the ceuse(s) Month, Day, Year)		
1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 6 Could not be determined 29e. Certifier (Check only one) 1 Certifying Physical Examine	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Special Clan: To the best of my known and manner stated. 7	Injury ome, farm, stre fy) owledge, death ation and/or inv	M 1 Coet, fectory, office occurred at the trestigation, in my	me, date and place opinion, deeth occurs on umber - 2 6 0 9	o, end due to the urred at the time,	vn, Stete) cause(s) and menn date and plece, and	er as stated. If due to the ceuse(s) Month, Day, Year)		

DHMH 16 Rav 6/95

ORIGINAL

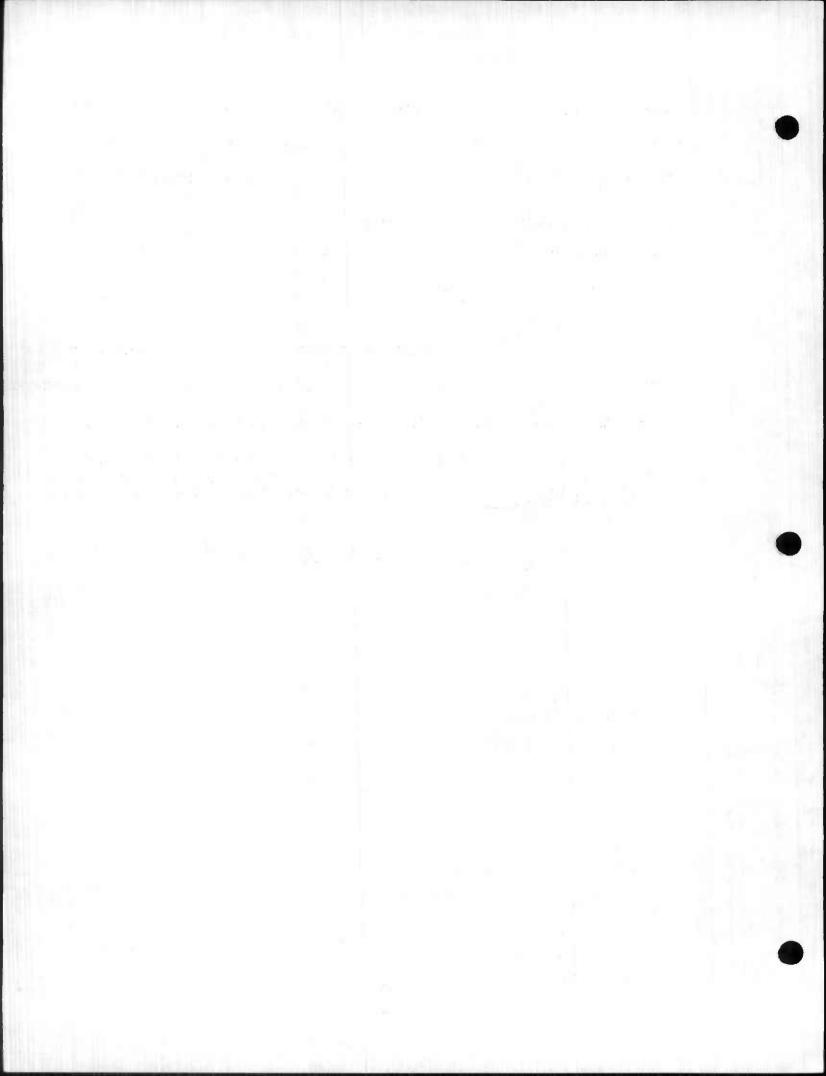


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** 9:20 PM ROBERT STEUDL, SR. AUGUST 21. 1999 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF GLEN BURNIE GLEN BURNIE ANNE ARUNDEL If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F 71 Yrs. Director MARYLAND 217-24-6157 JAN.7, 1928 Usual Rasidence of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits show r 28a-f show 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 muntbe 7829 SOUTHWEST ROAD 21122 U.S.A. **І**таптв 23a Funeral 12. Was Dacedent Ever in U.S. Armed Forces?

**Miles 2 in No 1946 - If Yes, Giva Year or Datas: 1947 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - American Indian, Biack, White, etc. traumatic event, the Madical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0020 9 Specify: WHITE 1 Yes 2 No Specify: à 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7, the end Mentel Hygiene.
7 Is marked other than "ne Elamantary/Secondary (0-12) College (1-4or 5+) MECHANICAL ENGINEERING U.S. GOVERNMENT 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) **JAMES** STEUDL RUMNEY HELEN ELIZABETH 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit Peges 1 and 2 st Department of Health enc Important: if Itam 27 is n MRS. CARLEEN STEUDL 7829 SOUTHWEST ROAD, PASADENA, MARYLAND 21122 (WIFE) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from Stata LOUDON PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 8/26/99 BALTIMORE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 tagan 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haer failure. List only one chause on each line. erval Bet Onaet and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a conse physician ar s the buriel-t Box 68760 Physician/Medical Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of centh? o been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown Δ. Records, À 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? page 1 Yes 2 No certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was cese raferrad to medicei examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 □ Ne Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide artifying Physician: To the best of my knowledge, death occurred at the time, data and piace, and due to the causa(s) and manner as attated. 29a. Certifier Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29b. Signatura and title of 29d, Date igned (Month, Day, Year) 90 30. Nama and address of perac completed ceuse of death (tem 23a) (Type, Print) 3708 Mountain 31. Date filed (Month, Pay, Year) AUG 2 5 1999 2. Registrar's Signature Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month Joseph J. Scarpulla 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) of Death 4c. County of Death Stella Maris/Mercy Baltimore N/A 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2□ F Months Deys Hours 217-18-6437 77 Yrs. 6/22/1922 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. inside City Limita MD N/A Baltimore 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 924 S. Robinson Street 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 15 Never Married 2 ☐ Married Specify: White 1 Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Scarpulla Josephine Veneziana 19a. Informant's Name/Relationship (Type, Print)
John Scarpulla/Brother 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5134 Wright Avenue Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 8/25/99 Baltimore, Maryland lst United Evangelcal 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or per lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? nificant conditions cook buting to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 ☐ Yes 2 ☐ No MARIS AT MERC 25. Was cese referred to medical examiner? 26. Place of Death (Check only one STE) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpicE 1□ Yes 2□ No 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? 1 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Vin Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date aigned (Month, Day, Year)

BAHIMORE

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Hospital **Physician**

/Medical

Director

Funeral

by

Completed

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Modical Exampler must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death v
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 28a any Injury or other traumatic event, the Medical Exercises 2008.

Physician /Medical

Examiner

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the ettending physician

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page 2

funeral director.

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Examiner

Physician/Medical

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Certification:

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Maryland 21215-0020

altimore,

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Registrar

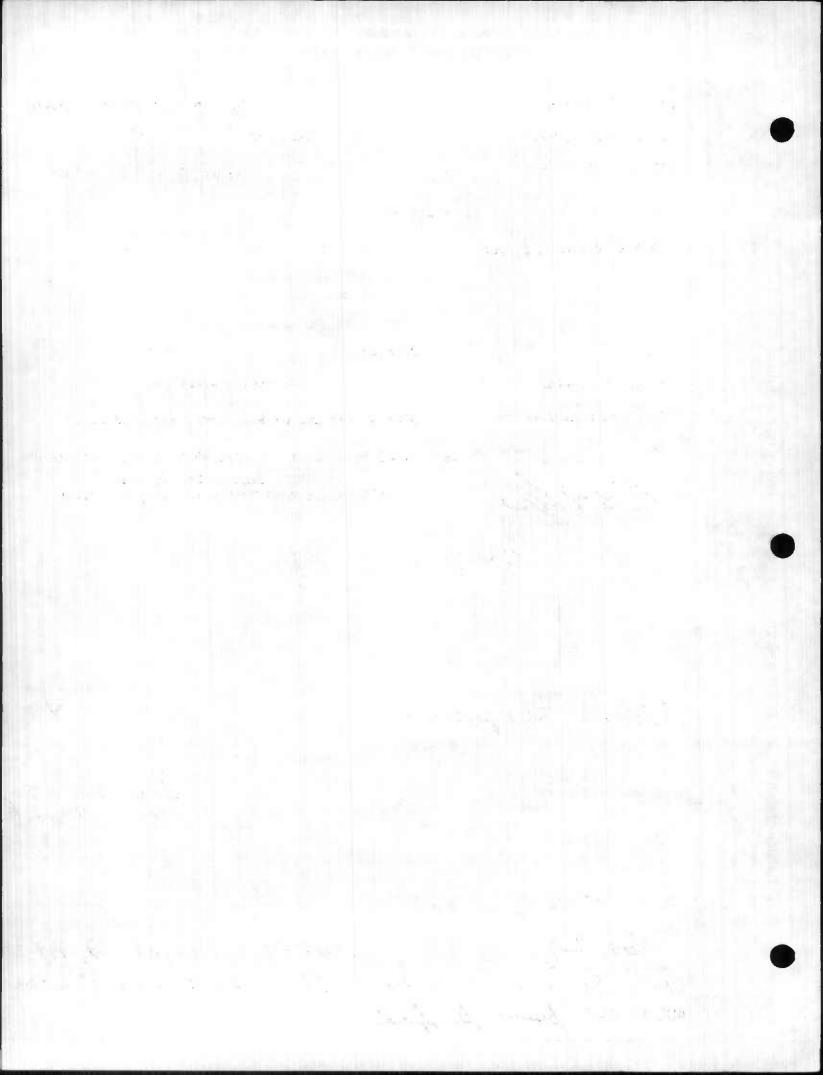
31. Date filed (Month, Day, Year) AUG 2 5 1999

29b. Signature and title of certifier

30. Name and address of person with

completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 20, 1999ar Mildred E. Schmidt 11:00 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore If Under 24 Hrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 216-14-0497 1□M 25F Yrs. 1922 Director July 2, Maryland Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location Parkton 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 20XNo Director 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number Items 23a or U.S.A. 17505 Bushland Road 21120 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 1 ☐ Yes 2 🖾 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☐ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 'netural'. Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w. Department of Heelth and Mentel Hygien. Important if Nem 27 is marked other that 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be FRank Davids Eva Hands 2 19e. Informent's Neme/Reletionship (Type, Print) Rodney D. Schmidt/Son 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17505 Bushland Road Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1€ Burlel 2 Cremetion 3 Removel from State 8/24/99 Gardens of Faith Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) al Service Ligensee 22. Neme and Address of Facility 21. Signature of Fune John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Chronic /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): 22 EINOM2 be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): and physician Box 68760 Physician/Medical the Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 Seletores 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 5 signed t Division of Vital Records. by 24b. Were sutopsy findings available prior to Completed 24e. Wes en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 2 4 - Homicide 24 hours aft Funeral Di pletely filled in Medical 29e. Certifier First Ing Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. within 2 To the i 29c. License number 4 29d. Date signed (Month, Day, Year) 29b. Signatu of berson who completed cause of death (Item 23a) (Type, Print) 2300 31. Date filed (Month, Day, Year) AUG 2 5 1999 32. Registrer's Signature State Registrar

AHO

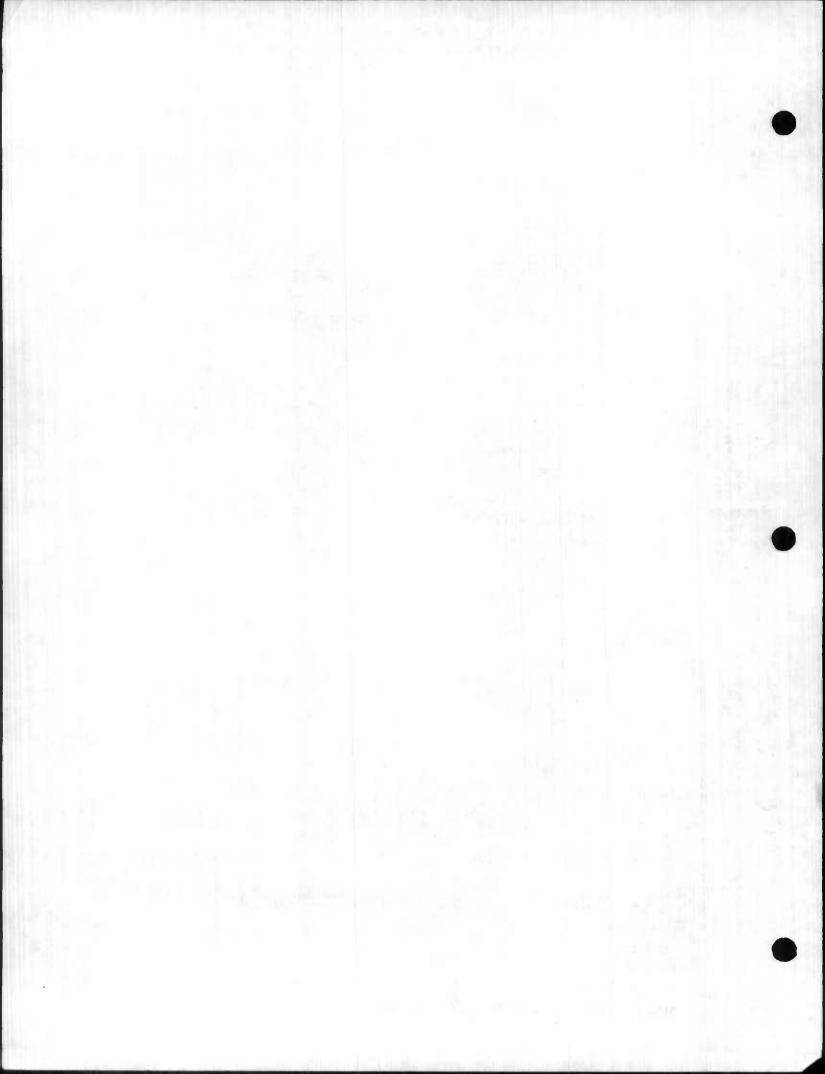
DHMH 16 Rev 6/95

					Certificate	of Death		Reg. No.	9 2	6670	
Physician /Medical		Decedent's Nama (First, Middle, L Avretta Sc	unerder		2. Data of Death Month Day Year AVGUST 22 1999 33						
aminer		Facility Name (If not institution, gi	ve street and number		Hospital	BAC	m, or Location of Deal		of Death		
eral ctor		Social Security Number 234-26-7417	Sax 7. A 1 M 2 X F	ige (In yrs. la 82	st birthday) If Under 1 Wonths Yrs.	Year If Under 2 Days Hours	Min. (Month, Da	rth ay, Yea <i>r)</i>	9. Birthplac Country WV	ce (State or Foreign	
wr then "natural", or items 23a or 28a-f show 4, the Medical Examiner must be notified at Completed by Funeral Director	Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location									I. Inside City Limits 1 ☐ Yas 2 ☑ No	
	10	Da. Street and Number 7403 School A	Code 1 2 2 2		10g. Citizen of V	What Country	n				
		I. Maritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forcas 1 U Yas 20 If Yas, Giva Yaar or Datas:	?] No		nt of Hispanic Orig y Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		e - Amarican ck, Whita, etc	o	
		15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		5+)	16a. Decedent's Usual (Give kind of work lite. DO NOT use	done during most	of working	16b. Kind of Bu	usiness/Indu	stry	
Be Com		8 7. Fether's Nama (First, Middle, Las			Homemaker		's Nama (First, Middle	OWN H			
Tof	_	Fay E. Bonnel			19b. Malling Addrass (ina Davi		State, Zip C	ode)	
	20	Richard Schne Da. Method of Disposition 1 월 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	Removal from State	cer	7403 School On The Property of	of per place)	Aug 25	ore, M	City or Town	n, Stata	
any injur		21. Signatura of Funaral Service Licensee Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222									
ian ical	In	3a. Part1. Entar the disease, or con shock, or heart fallure. List only nmediate Causa (Final isaasa or condition			Do not enter the mode	or dying, such as c	argiac or respiratory a	irrest,	tr C	pproximate iterval Between baset and Death	
niner	re	esulting in death)	a		as a consequence of):	Pnew	nonia			SA YS	
<u> </u>	Le	esulting in death)	a	Dua to (or a	as a consequence of):	Pnew	nonia		1	PARS	
edical Examiner	Sit co	equantially list conditions, any, leading to immadiate ause. Enter Underlying ause (Disease or injury at initieled evants southing in death) Last	a	Dua to (or a		Pneur	nonia		1		
tached for use as the burial-transit Thysician/Medical Examiner	Sit co	equantially list conditions, any, leading to immadiata ause. Enter Undarlying ause (Disease or injury act initieted events	b	Dua to (or a	as a consequence of): as a consequence of): as a consequence of):		23b. Did	tobacco use co	ntribute to ti		
be detached for use as the burial-transit by Physician/Medical Examiner	Sit co	equantially list conditions, any, leading to immadiate ause. Enter Underlying ause (Disease or injury at initieted evants southing in death) Last	b	Dua to (or a	as a consequence of): as a consequence of): as a consequence of):		23b. Did	_	ntribute to ti	he cause of death? bly 4 Unknow autopsy findings able prior to	
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31. Data filed (Month, Day, Year) AUG 2 5 1999 Registrar

32. Registrar's Signatura Spouls



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Daath Month 08 **Physician** Sister Mary Ignatius Toodle, OSP 9:15 a.m. /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oblate Sisters of Providence (HCU) Catonsville Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Hours 1□ M 2□ F 90 220-58-1392 08-21-09 MD Usual Residence of Decedent 10a State 10c. City, Town or Location Baltimore 10d. Inside City Limits (Catonsville) MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21227-3899 USA 701 Gun Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married Specify: African-1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education fy only highest grade completed) 16b. Kind of Business/Industry (Specify Elementary/Secondery (0-12) College (1-4or 5+) School Teacher 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Phyllis Ann Cooper George Andrew Toodle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21227 Sister M. Alexis Fisher, OSP 701 Gun Road Baltimore, MD 3899 20b. Place of Disposition (Name of cemetery, crematory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery8-26-99Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Section Iconosee 22. Name and Address of Facility
March Funeral Home West 4300 Wabash Avenue 23a. Part 1. Enter the dispuss, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or one in line. Approximate Intarval Between Onsat and Daath Immediate Cause (Final . ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) NSTANTA - NEOUS Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Physiclan/Medicai Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 28. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 25 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Note to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8-25-99 D18362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Ave. Suite 308. Balto. Md2/229 OMAL K. DANG M.D. 32. Registrar's Signatura 31. Date filed (Month, Day, Year)

State Registrar

AUG 2 5 1999

Funeral

Director

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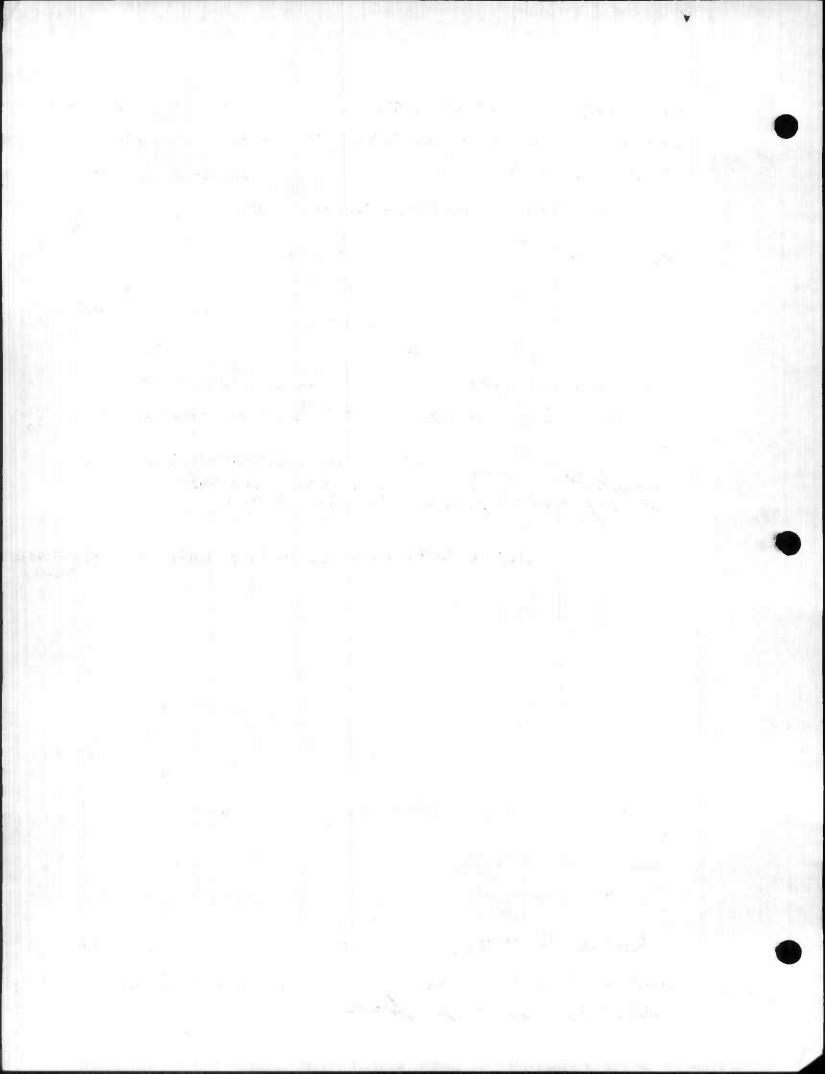
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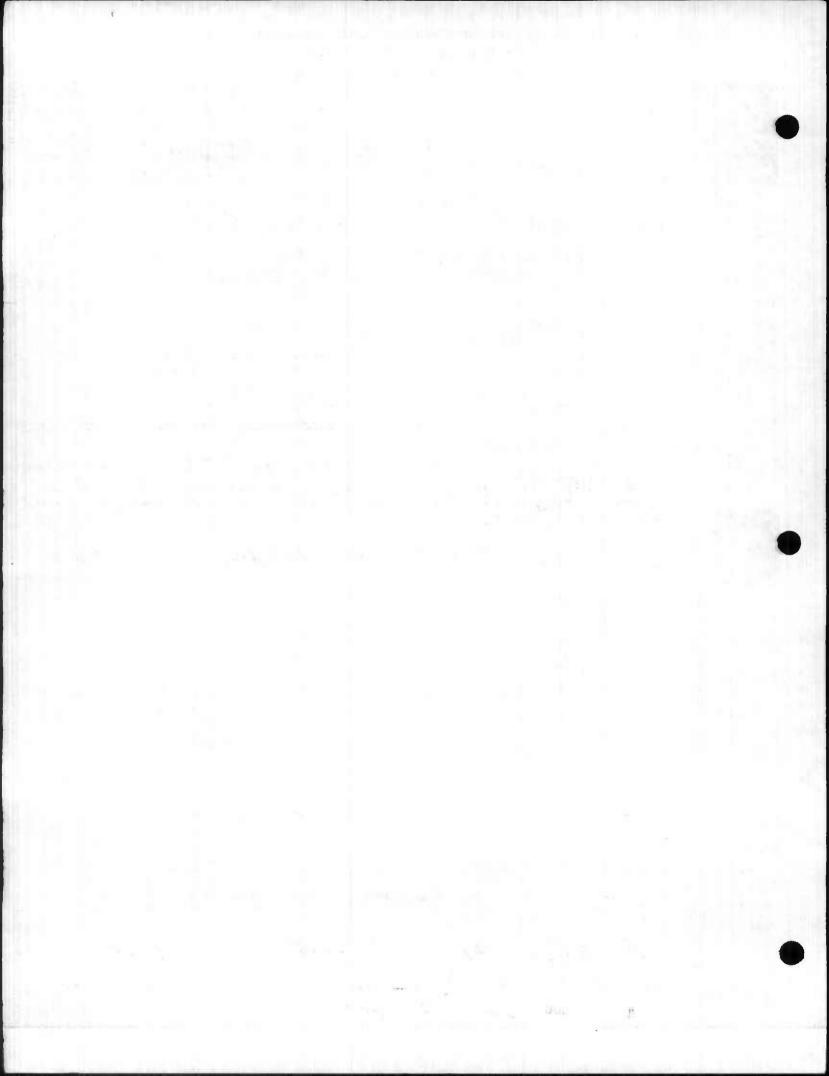


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State of Maryland / Department of Health and Mental Hygiene 26672

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DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20, 1999 rugust 9:30 GEORGE TONGUE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 07 Hospital Baltimore Baltimore omai If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign ANTIGUA WEST **Funeral** Months Days 101M 2□ F 81 Director 04 - 09 - 1.8UNKNOWN INDIES Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla Ih and Mantal Hygiens. In the Add Mantal Hygiens ?? Is marked other than "natural", or itema 23a or 28a-f show traumatic avent, the installed Examine count to another a N/A BALTIMORE MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. Funeral 5110 BELLEVILLE AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) LIVE STOCK LABORER 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other treumstic avant page. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SIDNEY TONGUE MARY WILLIAMS 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA REYNOLDS, NEICE 5110 BELLEVILLE AVE, BALTO, MD 21207 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremetion 3 Removal from State MOUNT ZION 8-30-99 BALTIMORE, MD 4 Donation 5₁□ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 complications that caused to death. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final verwhelming disease or condition resulting in death) Examiner Due to (or as e consequence of): Examine 2 Sior Ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760 8 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 Unknown signed by 1 Yaa 2 No Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed No 1 X Yes 2 No 25. Was case referred to medical examiner?

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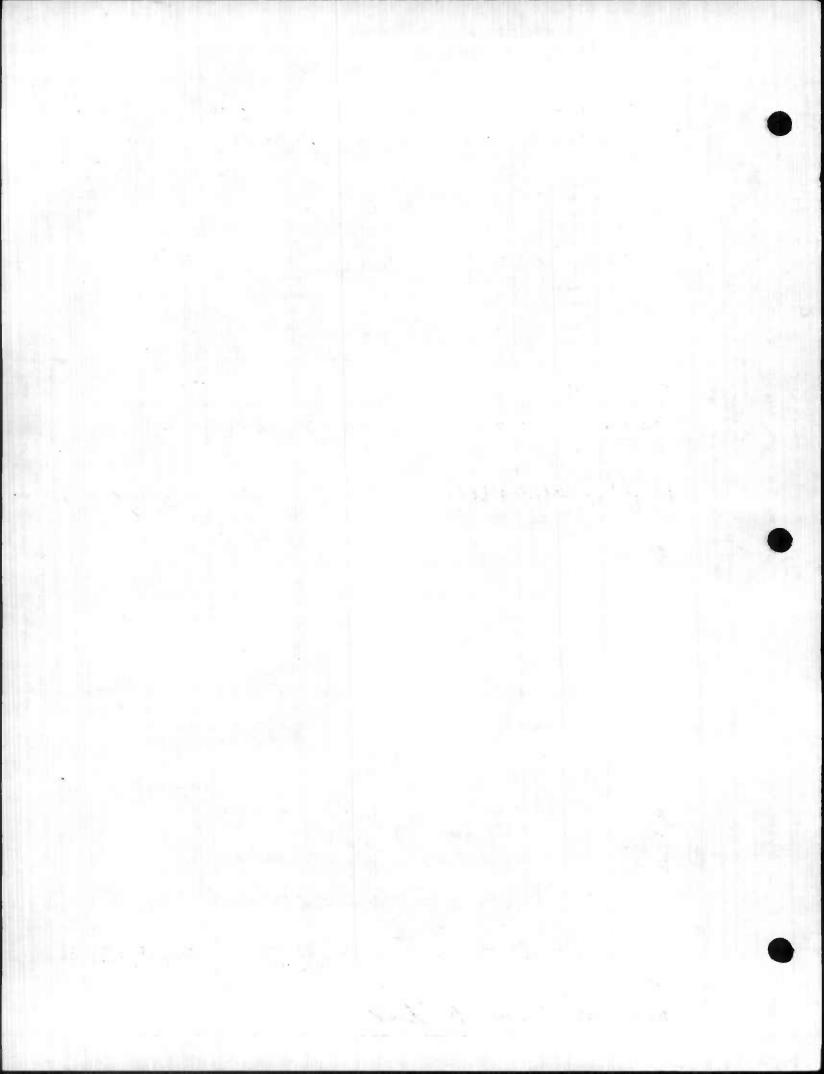
27. Manner of Death Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 2 ER/Outpatient 3 DOA this 26a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? at or Attending P s after death.
I Director: After to in by the funer After 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 | Homicide To the Hospital of within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Redicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier RES -000 August 20, 1999 2401 West Belvedere Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital, Erondu MD. Ph.D. Baltimore, Maryland

State Registrar 31. Date filed (Month, Day, Year)

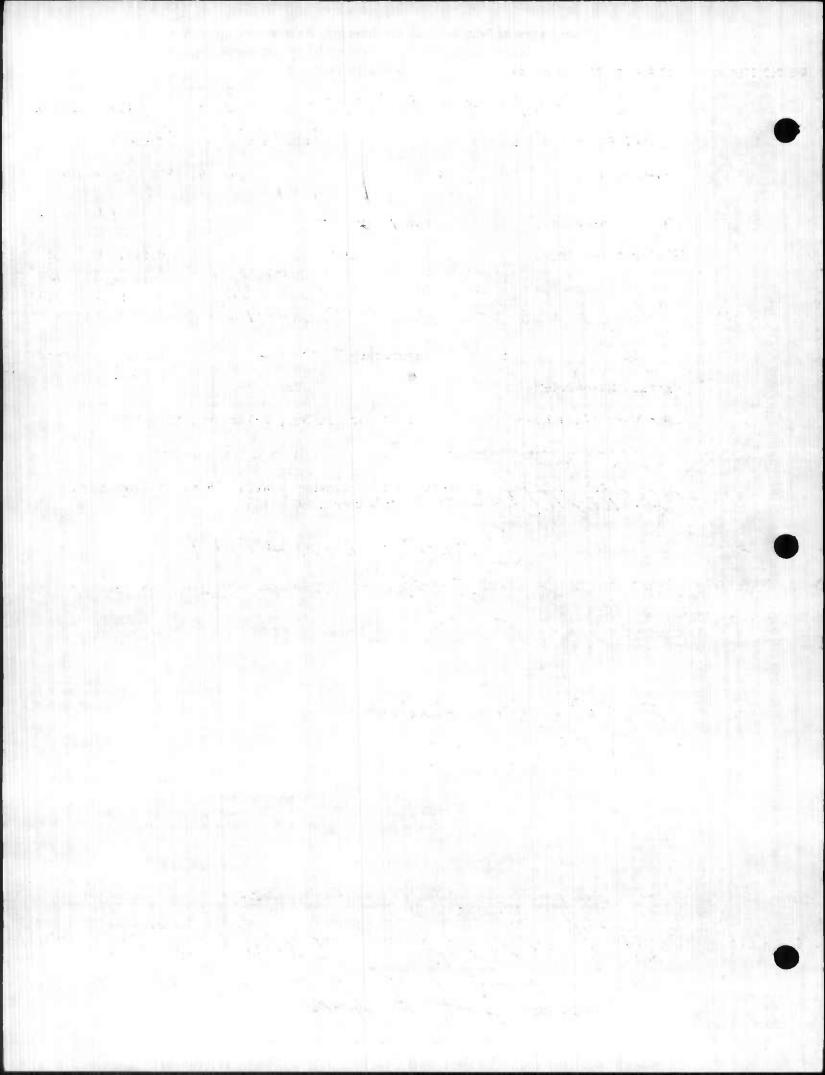
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32. Registrar's Signatura



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1 ☐ Yas 2 27. Mannar of D 1 XXNetural	5 Pendin	28a. Data o	npatiant 2 D of Injury h, Day Year)	ER/Outpatie 28b. Tima Injury	of 2	8c. Injur Wor	4LI NU		-		e 8 □Oth injury occur	nar (Specify, rred)
2 Accider 3 Suicida 4 Homici	6 ☐ Could I		of Injury - At hong, etc. (Specif	ome, farm, s					28f. Locat City o	ion (Street or Town, S	et and Numi State)	ber or Rural	Routa Number,
29a. Certifier (Check only	Certifyin		isis of axamina	wledge, dea tion and/or i	ith occurred nvestigetion	et tha tir	me, dete an opinion, daa	d place, th occur	and dua to red at tha t	tha caus	a(s) and m and place,	anner as sta and dua to	ated. tha causa(s)
one) end mannar statad.									1	ay, Year)			
	/ John	111	1				1	/ /	/	1	2///	14	2
29b. Signature	de	who complated cause	a of death (Item	23a) (Type	o, Print))	53	61	2	0	7/11	17	7.

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 024 PM 1999 Wimple 4b. City, Town, or Location of Death Spancer Wimple

4a Facility Name (If not institution, give street and number) 23 /Medical 4c. County of Death Examiner Medical Center Baltimore
If Under 24 Hrs. 8.1 Baltimore If Under 1 Year 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 231-12-6262 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County tem 27 is marked other than "natural", or itema 23a or 28a-f ahow other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Mary and Director 10g. Citizen of What Country? 101, Zip Code LId Funeral Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, While, etc. Wes Decedent Ever in U.S. Armed Forces? 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other treumatic event, the Mexical Examined DOCO. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Applicity: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working ttle. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TO, 1 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
JOSEPH L. KU
ZZZZ W. Nort 5 North Ave. to. Md. Enter the all seese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, or nearthallure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Distress Syndrome Examiner Physician/Medical Examiner Bronchitis ettending physician end for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Pulmonary Fibrosis by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpalient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident i or Attend after death Director: 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1/2 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and menner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 340 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10 N. Greene St, Baltimore, MD 21209

State Registrar

DHMH 16 Rev 6/95

Harold

31. Date filed (Month, Day, Year)

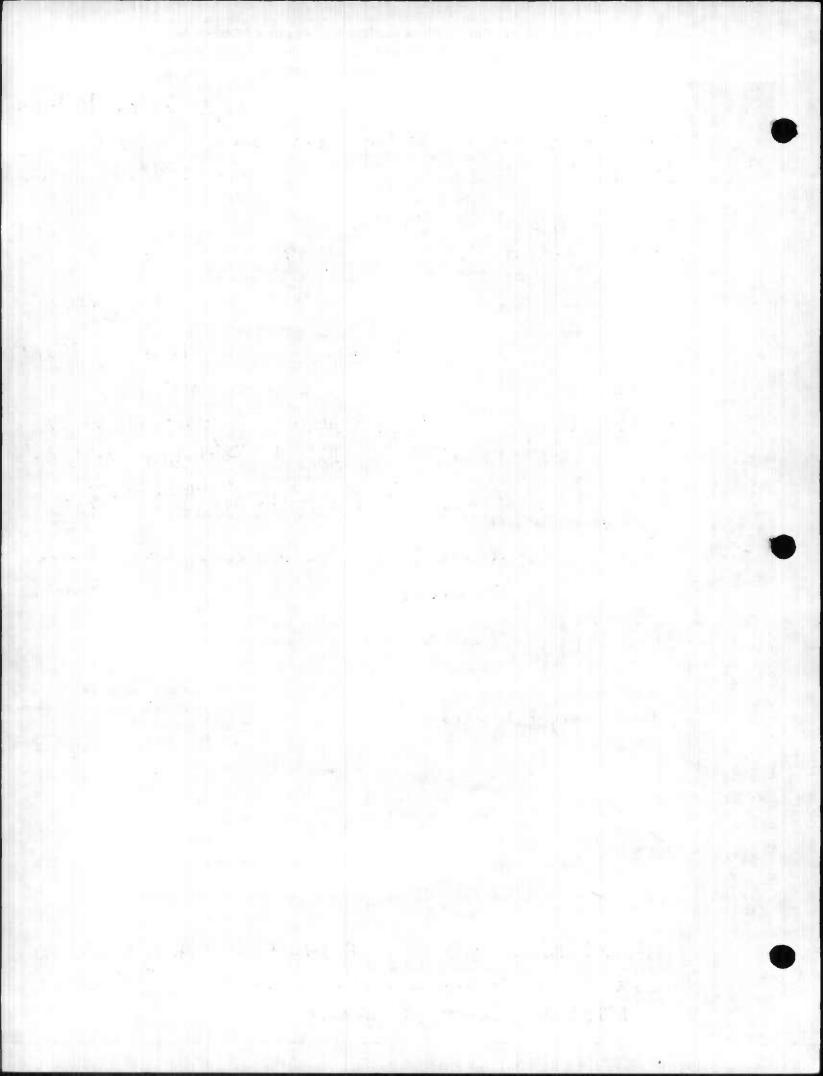
Pierre

AUG 2 5 1999

MD

BVAMC

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:40gm WARD SR, AUGUST RANKLIN 4a Facility Name (If not institution, give street end number) BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) HOSPITAL NIA AGNES If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 1 MM 2□ F Months Days 215-16-6747 Yrs. 6 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE CIT MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 705 USA. MILTON AVENUE 12. Was Decedent Ever In U,S. Amed Forces? 1 M Yes 2 □ No 6 - //- 47 If Yes, Give Year or Dates: 2 - 15 - 49 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Biack, While, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 28 No Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etementary/Secondary (0-12) Coilege (1-4or 5+) HARBORSON & WALKED 10+HGRADE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) EDWARD UNKNOWN 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3617 EDMONDSON AVE. BALTIHORE, MD. 21229 lace of Disposition (Name of Date 20c. Location - City or Town, State VANESSA WARD LUCAS (DAUGHTER) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Remove from State CROWNS VILLE CEMETERY 8-27-99 CROWNSVILLE, MARYLAND 22. Name and Address of Facility/ JOSEPH H. BROWN JR. FUNERAL HOME 4 □ Donation D Other (Specify) Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death 30 YVS Atherosclerotic Cordiovacculor Diseas Immediate Cause (Finat disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury fhat initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably Wunknown Insulin Rependent Diabetas 1 Yes 2 No 24b. Were eutopsy findings available prior to 24e. Was an autopsy performed? Brain Stem Jufaret completion of cause of death? 1 ☐ Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1-ENatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end menner stated. 29b. Signature and B

Division of Vital Records, P.O. Box 68760, NAME From Klin Word

> Registrar DHMH 16 Rev 6/95

after death

To the Hospital within 24 hours a To the Funeral Completely filled

State

Physician

/Medical

Examiner

Funeral

Director

re 23a or 28a-f show

Herns 23a

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than

Physician

/Medical

Examiner

Examiner

Completed by Physician/Medical

Be

Certification:

Medical

Baltimore,

Director

by

Completed

31. Date filed (Month, Day, Year) AUG 25 1999

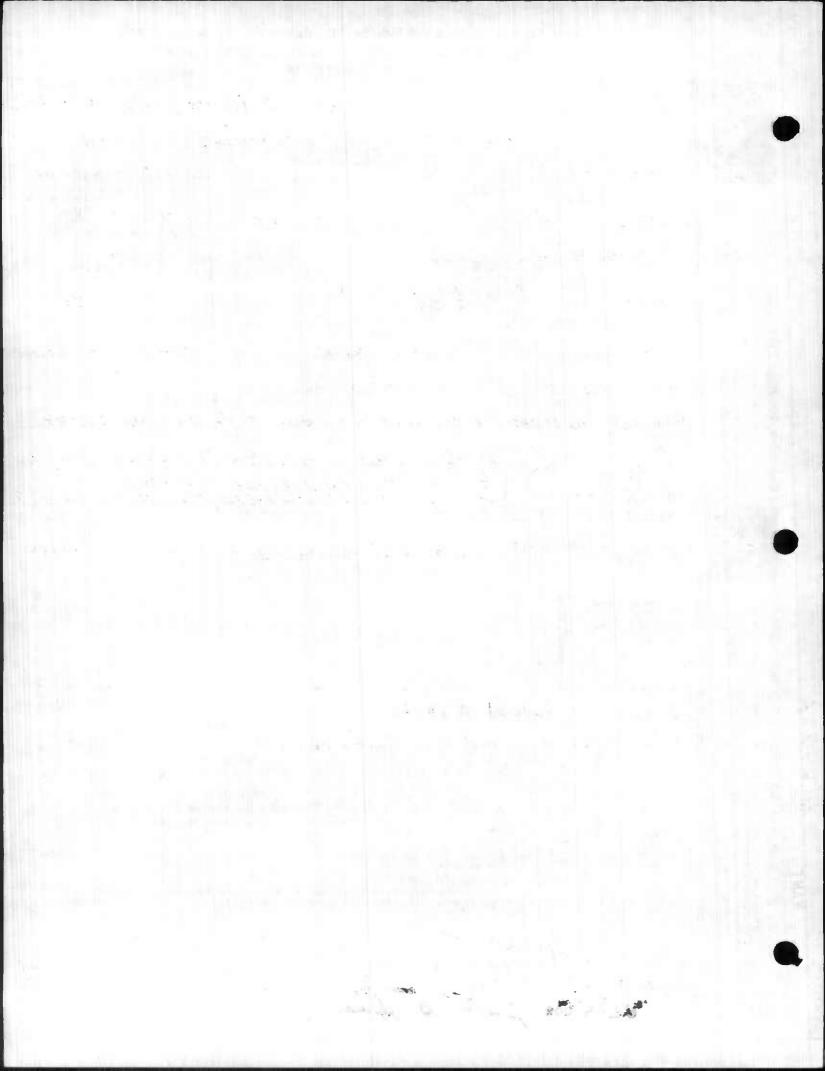
30. Neme end address of person who completed

Frydenbor 4

ceuse of death (Item 23a) (Type, Print)

D27315 Agres Hospita 1900 CATON AVENUE

29d. Date signed (Month, Day, Year) August, ZZ, 1999



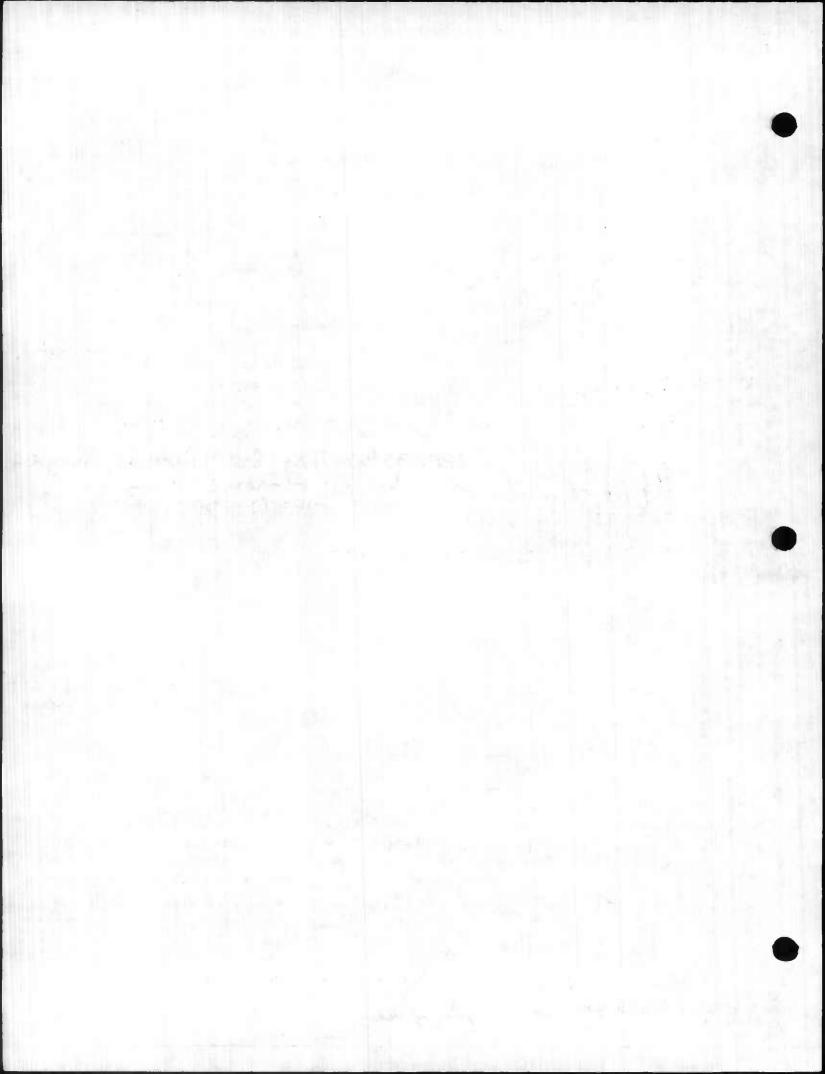
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be ex

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

n	1. Decedant's Nama (Fir.	et Middle I	:/)	2. Date of D	Reg. No		3. Tima of Death						
	LACY WAL		,,,		Month AUGU	Day	Year 1999	1618 PM					
	4a Facility Nama (If not i		r Location of Dear										
	SINAI HOS	PITAL C	OF BALT	IMORE			BALTIM	ORE		V/A			
Ì	5. Social Security Number			7. Age (In yrs.		Months Day					place (Stata or Foreign		
	UNKNOWN Usual Residence of Dece		MW S□ E	36	Yrs.	Converse reserv		01-15			TIMORE		
		County		10c. Cit	ty. Town or L	ocation				1	Od. Inside City Limits		
MD BALTIMORE BALTIMORE											1□Yes 2√2No		
	10e. Street and Number.	-				10t. Zip Code	i.		10g. Citizen of I	What Coun	stry?		
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To Be Completed by Fur	11. Marital Status	/	12. Was Dec Armed Fo		LS. 13	Was Decedent of If Yes, specify Co	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	0- 14. Rac	se - Americ sk, White,			
	1 ☐ Never Married 3 3 ☐ Widowed 4 ☐ f		f Yes, Gi Year or D	VB		1□Yes 2N	io Specify:		Specify	BLA	ACK		
	Transferron to the	Decedent's Ed	11/10/2015	ABIOS.	16a Dece	edent's Usual Occ	upation	7	16b. Kind of B	usiness/inc	dustry		
	(Specify on	ly highest grad	de completed)		(GiM	e kind of work dor DO NOT use reti	ne during most of we	orking	annio marge, es		ICAN II		
	Elementary/Secondary (0-12) College (1-4or 5+)					TI	RE REPA	IR		TIRE	REPA	IR SHOP	
	17. Father's Name (First,	Middle, Last)	è			01-0-0	18. Mother's Na	ame (First, Middle			SOUTH TO SEE SEE SEE SEE SEE SEE SEE SEE SEE SE		
	WILSON WA				Toposition a			WALLACI		2000	2007		
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	1 Mg Burial 2 □ Cre	mation 3 🗆		State A-O	cometery, ch	amatory or other p	Nace)	6 00 00	1-0.5	-	Maule		
l	4 Donation 5 0			MC	13010	2 Name and Add	fress of Pschity	3-28-77	HIBUI	w	11 my lan		
ı	Hollo Samello Apowell Funeral tome												
ŀ	23a Part1. Enter the dis	ease, or comp	Sications that	coulded the deat	th. Do not er	ter the mode of d	Ving, such as cardi	ac or respiratory	A G	Den	Approximate		
Examiner	resulting in death)			BUON	Chermony	#-CHEST				-			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth AUGUST 22 1999 CLARENCE WILLIAMS 8:25 AM 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give streat end number) 4c. County of Deeth GENESIS ELDERCARE KNOLLWOOD MANOR MILLERSVILLE ANNE ARUNDEL CO. H Under 1 Year If Under 24 Hrs. B Date of Birth Months Days Hours Min. March Day 1 Year 919 Marcy Land 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 1₩ M 2□ F 80 212-10-9201 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Pasadena 1 ☐ Yas 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 263 Maryland Ave. 21122 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Never Marriad 2 Merried 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Yes 2 1 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede complated) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collage (1-4or 5+) Plumber Self Employed 6 N/A 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) William G. Williams, Sr. Sadie Schaffer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna G. Williams Sister-In-Law 265 Maryland Ave. Pasadena, Maryland 21122 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca)
Glen Haven Mem. Park Aug. 26, 1999 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from State Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility McCully-Polyniak Funeral Home, P.A. Ecken 3204 Mountain Road Pasadena, Maryland 21122 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heert feilure. List only one ceuse on each line. Approximate Intervel Between Onsat and Deeth Myocardial Infacts in Due to (or es e consequenca of): Dua to (or es e consequence of):

Physician /Medical Examiner

physician and the burial-transit

Physician

/Medical

Examiner

Directo

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner rount be notified at

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumetic event, the Media once.

the Maryland

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

Physician/Medical Completed by Be Certification: To

signed by the a

pega 2 s certificate

To the Hospital or Attanding Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Immediate Ceuse (Finel diseese or condition resulting in death) Examiner

Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that Initiated avants resulting In death) Lest

25. Wes casa rafarred to medical

1 Yes 2 No

27. Manner of Deeth

2 Accident

4 - Homicide

(Check only one)

3 Sulcide

29a. Cartifier

1 Naturel

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Cereprovos andor 26. Plece of Deeth (Check only ona)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work?

28e. Pleca of Injury - At home, ferm, street, factory, offica building, atc. (Spacify)

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings evailabla prior to complation of causa of deeth? 24e. Wes en eutopsy pertormed? 1 ☐ Yes 2 XNo 1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Ccritifying Physicien: To the best of my knowladga, daath occurred et the time, data end place, end due to tha cause(s) and manner as steted. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Data signad (Month, Day, Year)

5 Pending

investigation

6 Could not be datarminad

D-40521

1 ☐ Yes 2 ☐ No

August 24,1999

30. Name end eddrass of person who complated cause of daeth (Itam 23a) (Type, Print) 7845 Ookwood Road Smite 205 OCKANE

ren burnie, no 21061

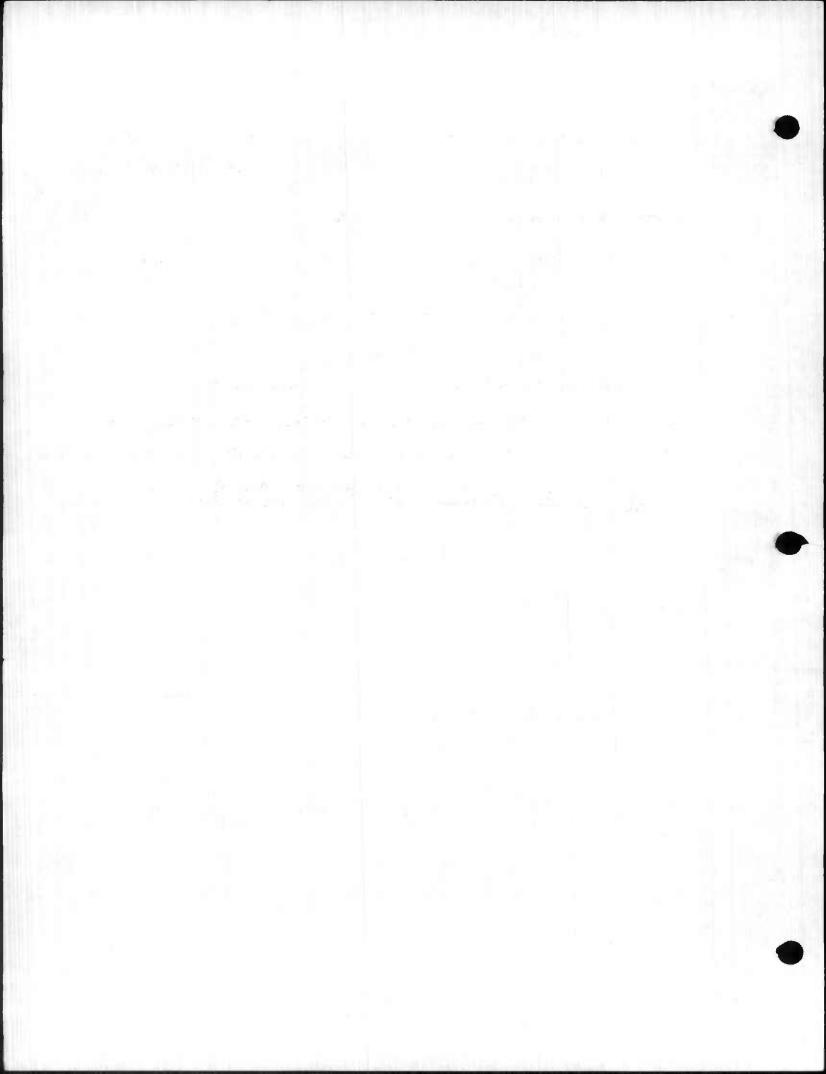
Registrar

DHMH 16 Ray 6/95

31. Data fllad (Month, Dey, Year) State

Medical

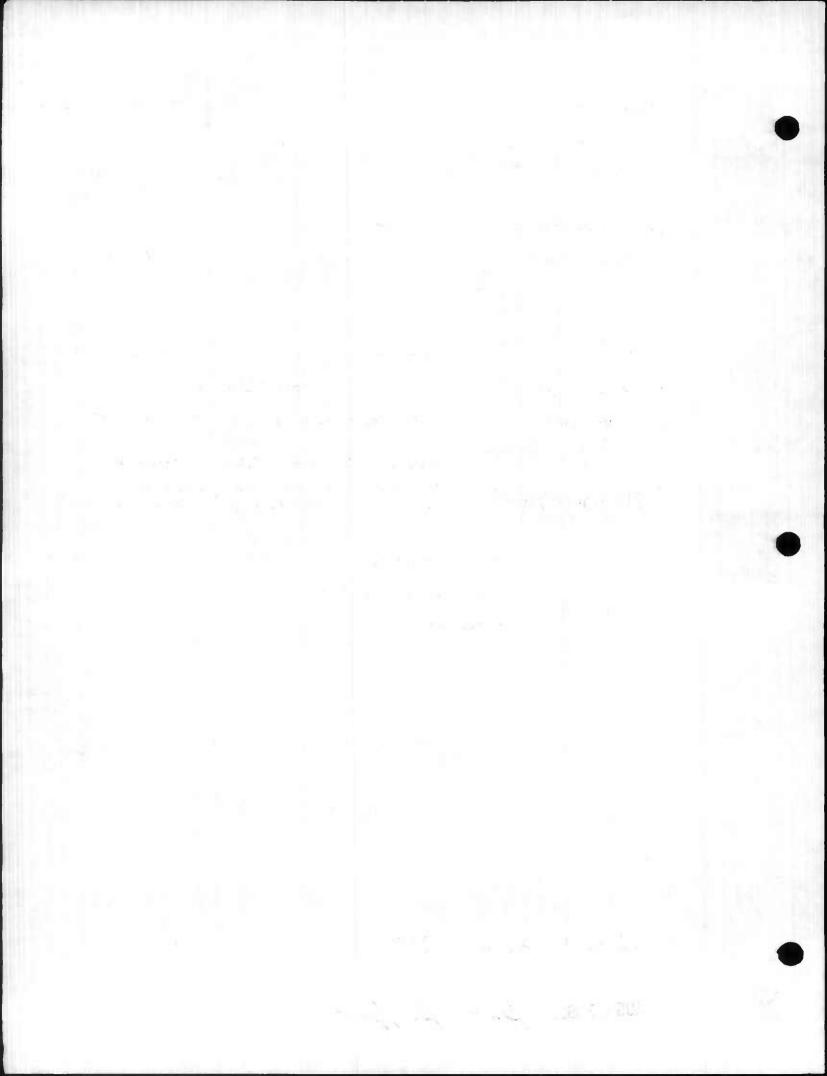
32. Ragistrar's Signetur



State of Maryland / Department of Health and Mental Hygiene

99 26679

0.1						Ce	nıtıcate	OT .	Death			Reg. No	0.			
	Physic /Medi		1. Decedent's Neme (First, Midd Ellen C. Yea			2. Date of I Month Augus	ate of Death Jonth gust 25 1999				na of Death : 05 AM					
	Exami		4a. Facility Name (If not institution Harbour Hosp													
	Funeral Director									8. Date of 8 (Month, 1	Birth Dey, Yeer 1, 19	908	Cou	nplace (St untry) rylar	ete o <i>r Forei</i> g 1d	
	Sa-f show	Director	Usual Residence of Decedent 10a. Stete 10b. County Maryland Anne			ity, Town or Lo	um								10	de City Limit Yes 2 🖾 N
	urs efter deeth v al', or items 23s Exemples must by Funeral	Dir	10e. Street and Number				10f. Zip (2			10g. Citizen of What Count				
020		by	306 Nancy At 11. Maritai Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	12. Wes De Armed	ecedent Ever in I Forces? s 2 X No Give Dates:	1			lispanic Ori an, Mexicei		ecify Yes or I Rican, etc.)	United Sta			rican india a, etc.	n,
0200-61212	within 72 hi iene. • than *natu	Completed	15. Deceder (Specify only higher Elementery/Secondary (0-12)		d) + (1-4or 5+)	(Give	dent's Usuai kind of work DO NOT use naker	Occup done retired	eation during mos d)	t of work	ing	i	(ind of B wn H	usiness/l	ndustry	
Maryland	ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, James Edward H	aupt					Mar	y El	e (First, Midd 1en Mi	lle, Meidei L1ho1	1anc	ne)		
Mai	ith and 17 is m		19a. Informant's Name/Rejetion: James Yeager (el Route Nun More,					
galtimore,	eges 1 an ant of Heal tt: if item 2 y or other		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5	3 Removal fro	m State	cemetery, cre	ece of Disposition (Neme of metery, cremetory or other plece)				Date 8/28/99	Date 20c. Location - City or Town, State			le	
Dali	pemit. P Departm Importar any injur		21. Signature of Funeral Service Licensee 22. Name end Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne								ne		1227			
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Finei disease or condition resulting in death)	a(Cardiac Due to	Arrhyt	hmia quence of):			Cordiac	or respiratory	anos,		1	Onset	i Between and Death
00 00 YO	certificate be executed anding physician and use as the buriel-transit	n/Medicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Hyperten	(or as a consec	quence of):	Lur	e						30 Y	ears
5	the death by the etter teched for	Physicia	Part II. Other significant condition	ons contributing to	death but not re	suiting In the u	nderlying ce	use giv	ren in Part I	l.			o use co			ues of deal
necolds,	aw requires s been sign 2 should be	Completed by							24a. Wa				as an eutopsy informed?		24b. Were eutopsy findin available prior to completion of ceuse of death?	
	The ete h										10	∃Yes 2	No 🏝	1	Yes	2□ No
Alfal	Physician: The this certificate ral director, peg	o Be	25. Was case referred to medice examiner? 1 ☐ Yes 2 ☑ No	Hoenitai:	☐ Inpatient 2□	☐ ER/Outpatier	· office	Oth	OF		h <i>(Check onl</i> ome 5□ Re		a 🗆 🗆		4.3	
	fle fle	Certification: To	27. Manner of Death 1 Nanturel 5 Pendii 2 Accident Investi 3 Suicide 6 Could	28a. Dat (Mo gation	e of Injury onth, Dey Year)	28b. Time o Injury	M 28	C. Injur Wor 1 🗆			28d. Describ	e how inju	ury occu	rred		
5	ipital or Attendi ours efter death. eral Director: A filled in by the fu		4 ☐ Homicide determ	nined 286. Ple	ce of Injury - At h	ity)			ne dete co	ud place		own, Stet	e)			rvumber,
	To the Hospital within 24 hours e To the Funeral C completely filled	edicai		Examiner: On the	basis of examination	etion and/or in	vestigation, I	n my o	plnion, dee	th occur	red et the tim	e, dete an	d place,	and due	to the ceu	ise(a)
)	To the To the Comp	W	29b. Signeture and title of certifie	i		MD			7743					25,	1, Dey, Ye 1999	ar)
(NO		30. Name end eddress of person L. Seenivasan	, MD 606				mor	e, Ma	ryla	nd 212	225				
	Sta Registi		31. Date filed Worth, Dev Year AUG 2 5 1	99 3	Registrar's Sign	neture .	Soul	2								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** AUG 1999 11:50am VIRGINIA R 24 YEAGER /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospice of Baltimore - Gilcrest **Baltimore** Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

June 24 1916 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 X F 213-14-8696 83 Virginia Director 0 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Md **Baltimore** Essex 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 319 Stillwater Road 230 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: Herns Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status 1 Never Married 2 XMarried ò 1 ☐ Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorcad "natural" 15. Decadent's Education 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Carlo D. Persrghin Celide Rossi 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) mportant: If item 27 la Ruth Franta / daughter 6428 Bricktown Circle Glen Burnie Md. 21061 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 6 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro CrematoryInc. 8/25/99 Baltimore Md. 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility Connelly Funeral Home of Essex 0 300 MAce Ave. Baltimore Md. 21221 noticetions that caused the death De not enter the money cause on each line. Onset end Deeth Physician Immediate Cause (Final mon the AnomA diseese or condition resulting in death) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were sutopsy findings available prior to Completed 24e. Was an autopsy completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

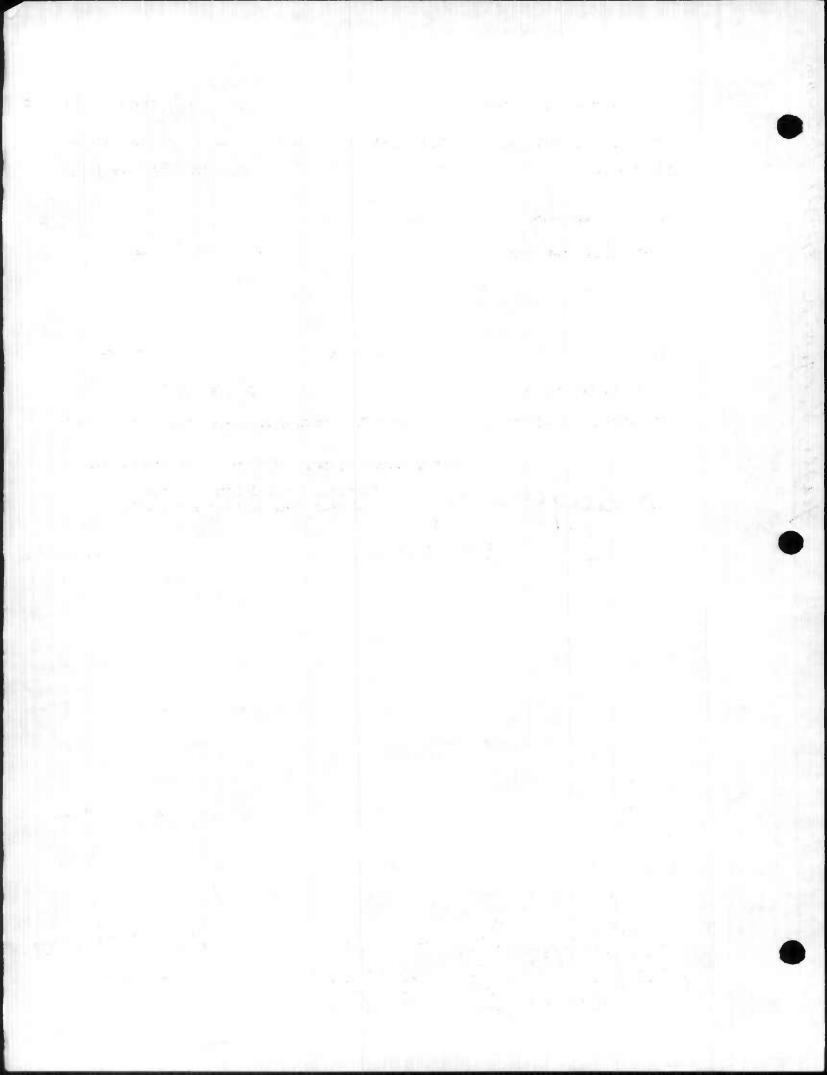
To the Funeral Director: After this certifica completaly filled in by the funaral director, i Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICC Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No o 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Medical Certification: Division 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier 29b. Signature end de of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 025205 completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto, md 21208

32. Registrer's Signature

DHMH 16 Ray 6/95

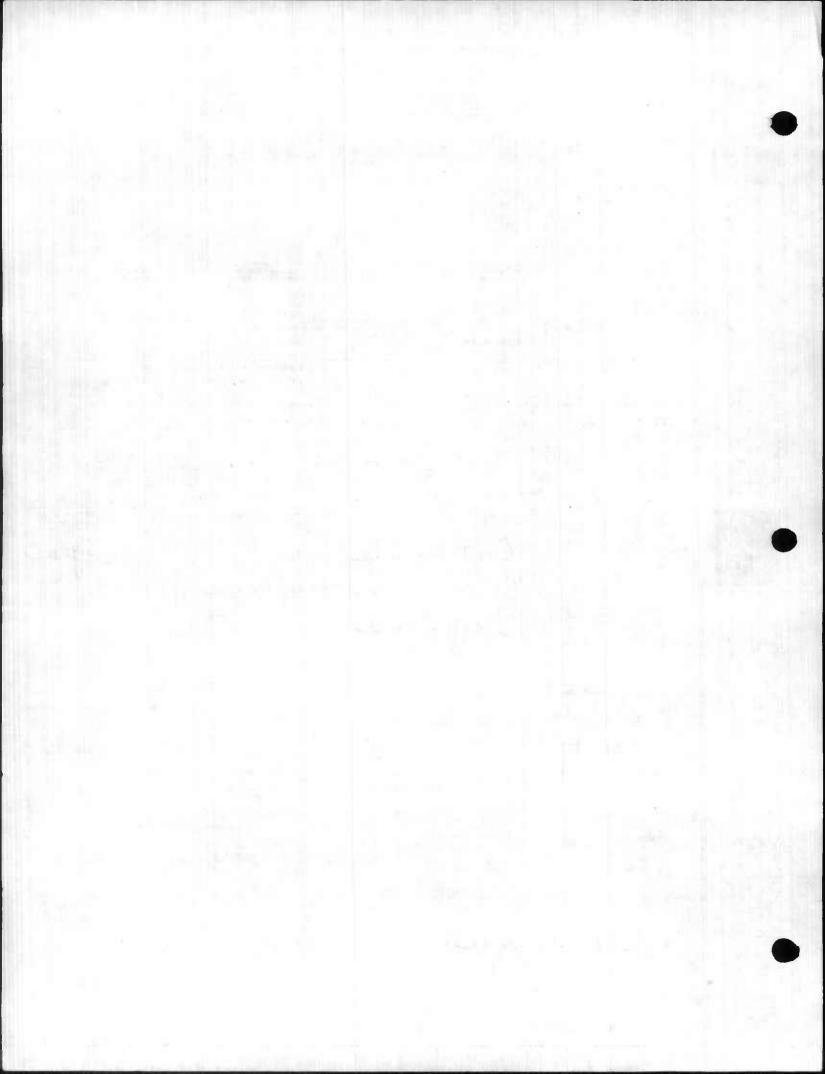
State Registrar



				State of Ma	-	Departme Certifica				giene Rog. No.	2	6681
	Dhysisian		me (First, Middle, Las	0					2. Dete of Der Month	ath Dey	Year	3. Time of Death
k,	Physician /Medical	Pauline	Sylvia Yo	ung					August	24, 199		3:00a.m.
	Examine		(If not institution, give					4b. City, Town, or L		4c. County	of Death	
			gecomb Cir		Marine to a to be	is a If I loc	ser 1 Year	Baltimon If Under 24 Hrs.		n/a	0.000	10 5
	Funeral Director	5. Sociel Security 218–28– Usual Residence	8846	7.4. 000 0	(In yrs. last bir 66	Yrs. Month		Hours Min.	8. Dete of Birt (Month, De April 1	3, 1933	9. Birthpil Count Md	ace (State or Foreign ry)
	pue Ru	10a. Stete	10b. County		10c. City, Towr	n or Location					10	Od. Inside City Limits
	Mary Heat	Md.	n/a		Balti	more						1□ Yes 2□No
	or 28a-f all	10e. Street and N	lumber			10f. 2	Zip Code			10g. Citizen of V	Vhat Count	ry?
	h with		gecomb Cir	cle South			2121	5		USA		
020	72 hours after death with the Maryland natural, or hems 23a or 28ad show deal Engine must be notified at what hy Ennancial Directors	3 Widowed	orried 2 Merried 4 Divorced	12. Wes Decedent Evaluated Forces? 1 Yes 2 No If Yes, Give Year or Detes:		If Yes, sp	pedent of F pecify Cub 2 to the	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		e - America ek, White, e	otc.
21215-0020	ed within 72 hours yglene. wr than "netural", ft, tre Medical Ex.	(Sp	15. Decedent's Edi ecify only highest grad	le completed)		Decedent's Us (Give kind of I life. DO NOT	sual Occup work done	pation during most of work d)	ing	16b. Kind of Bu	usiness/Indi	ustry
212	iene. The Men	Elementery/Se		College (1-4or 5+) C1	erk		-,		Social	Secur	ity
	EIRE e	17. Fether's Nem	e (First, Middle, Last)					18. Mother's Nam	a (First, Middla,	Maidan Sumam	-	
/iar			S. Dorsey					Pauline	Dickers	on		
Maryland	and and and and and and	19e. Informent's	Neme/Relationship (7)	ipe, Print) Daught	ter 196	. Mailing Addra	ss (Street	and Number or Rui	ral Route Numbe	er, City or Town,	Stata, Zip	Code)
-	1 and Health em 27 ither tr		te V. Boyd					venue Bal				
altimore	802	20e. Method of D	isposition 2 ☐ Cremetion 3 ☐I n 5 ☐ Other (Specify)	Removel from Stete	cemeter	Disposition (A y, cremetory of lemoria	r other ple		Dete	20c. Location -		
altir	permit. Pag Department Important: it any Injury o		Furneral Service Licent		King M			ess of Fecility Nut	tor Fun	Baltimo:	re, M	a.
m	Ped Ped	1 Mr	nit R	+uru	H	2501	wvnn	s Falls P	KWY Bal	eiai no timore	Md	21216
Г		23a. Pert 1. Ente	r the diseese, or comp eert failure. List only o	lications that caused the	to death. Do r	not enter the m	ode of dyir	ng, such as cardiac	or raspiratory a	rast,	1	Approximata Intervel Between
	Physician	SHOOK, OF TH	son randie. Elst only c	And Caddoo Off addigment	0.1							Onset and Deeth
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Ć,	cate be assecuted physician and the bunal-transit		conditions, immediete deriving	8/155	O A	consequence o	n). /					
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0	y the a	Pert II. Other algi	nificant conditions co	ntributing to death but	not resulting in	the underlying	g cause giv	ven in Part I.	23b. Did	obacco une co	ntribute to	the cause of death?
۵.	E X D) a beter						10	Yea 2 No	3 Prob	ebly 4 Unknown
Records,	aw requires been so 2 should		besity							an eutopsy med?	eva	ore autopsy findings uilable prior to npletion of cause death?
	The tay ate has page 2		}						101	res 20 No	10	Yes 2□ No
Vital	ysician: The is certificate director, pag		erred to medical					26. Place of Dea	th (Check only o	na)		
of	hys hys	1 Yes 2	_] NO	Hospitel: 1 Inpatient			DOA			dence 6 □Oth)
	After funer	27. Menner of De	5 Pending	28a. Dete of Injury (Month, Day		rime of njury M	28c. Inju	ryet rk? Yes 2 □ No	28d. Describe I	now injury occur	red	
Division	death death ctor: y the	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be determined	28e. Place of Injur	v - At home, fe			1163 2 110	28f. Location (S	Street and Numb	er or Rural	Route Number,
2	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	4 Homicide	ootennined	building, etc.	(Specify)		,,		City or Tox			
	To the Hospital or Attending B within 24 hours effer death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier (Check only one)		sician: To the best of iner: On the basis of e end menner stets	xaminetion and							
	ithin ithin omple	29b. Signeture ar	nd title of certifie	end mention state		2	29c. Licens	se number		29d. Date signe	d, (Month, L	Dey, Year)
	L S F O	1 Dh	eldn H	redger	er m	.)	Do	2397		8/25	99	
	1 Ly	F 1	drass of person who o	. 0	ith (Item 23a) (Type, Print)	1	ee Rd 1	P 11. 1	1.1.0	717	2
	State	31. Date filed (Mo		22. Registrar	s Signature	r me	4 14	ee ich	1 4501	ya way	214	
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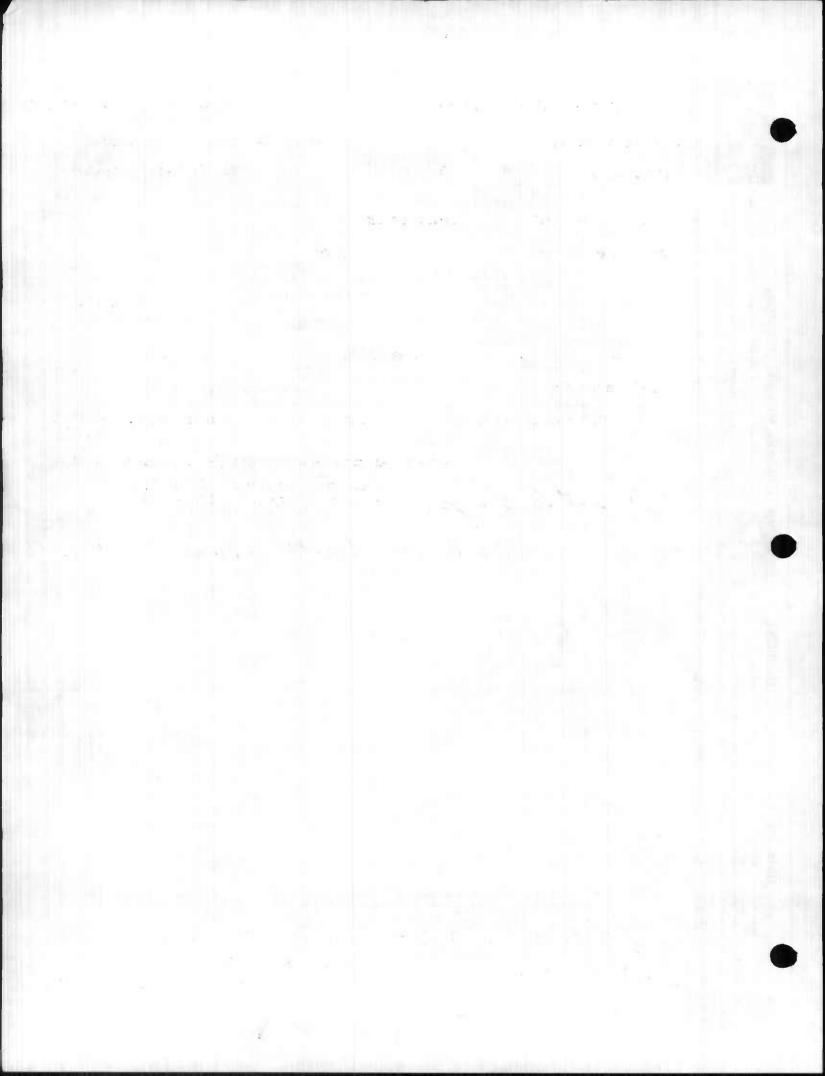


State of Maryland / Department of Health and Mental Hygiene 9 9

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				Certifica	te of	Death			Reg. No.			
	1. Decedent's Name (First, Middle, I	est)						2. Date of De		Vess	3. Time of Deat	h
Physician	Dolores	Elma Bald	win					August	Day 11,	1999	7:45 P.N	1.
/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)			T	4b. City, Tov	vn, or Loc	ation of Deatl		ounty of Death		
- ZAGIIIIICI	3205 Titan Terra	ce				Havre	de (Grace	н	arford		
Funeral		Sex 7. Aga	(In yrs. last birth		r 1 Year	If Under 2	24 Hrs	9 Date of Die	Ma	O. Distu	place (State or Fore	eign
Director	217-20-2092 Usual Residence of Decedent	1□ M 3 □√F	75 Y	rs. Months	Days	Hours	Min.	July 3	7924	Mary	Tand	
a manual	10a. Stata 10b. County		10c. City, Town	or Location	Mari	1.2					10d. Inside City Lim	nits
firer deeth with the Meryland r terms 23s or 28s-f show ther must be notified a	MD Harfo	rd	Havre	de Grac		.,,,,					1 □ Yes 23	No
th with the 23e or 2 ust be no	10e. Street and Number 3205 Titan Terr	200		10f. Z	p Code 210	70				of What Cou	ntry?	
s 23s		12. Was Decedent E	vor in II C	12 Was Door			uln? (Sne	cify Yes or No		Race - Ameri	can Indian	_
Urs effer Mr, or He by Fu	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	11/11/11	If Yes, sp	ecify Cub	oan, Mexican,	, Puerto F	Rican, etc.)		Black, White,		
1 21215-0020 led within 72 hours el bygiene. Per then "natural", or nt, the Modes Eram Completed by 8	15. Decedant's (Specify only highest g	Education rade completed)	1	Decedent's Usi Give kind of w	ork done	during most	of working	ng	16b. Kind	of Business/In	dustry	
Z1Z1	Elamantary/Secondary (0-12)	Coilege (1-4or 5+	-)	life. DO NOT		ed)			T., b.			
nd 2	10 17. Father's Name (First, Middle, La	0	HO	memaker		18 Mothai	r's Nama	(First, Middle	In ho			_
re, Maryland s 1 and 2 should be filed t Health end Mental Hyg tem 27 is marked othe other traumatic event,	William Wettig					Elma			,			
Aary 2 shou end N is mer	19a. Informant's Name/Ralationship			Mailing Addras	,						1.7	
1 and 2 Health com 27 I other tr	Benjamin F. Bald	win (Husban	d)	3205 Ti	tan	Terra	ce, I	Havre o	de Gra	ice, MD	21078	
	20a. Mathod of Disposition 1⊈ Burlal 2 ☐ Cremation 3	☐Removal from State	20b. Place of cemetery	Disposition (Ne , cremetory or	other ple	ece)		Date	20c. Local	tion - City or T	own, State	
tim men tant: jury	4 ☐ Donation 5 ☐ Other (Spec	eify)	Harfor					/16/99	Aberd	leen, M	aryland	
Baltimo pemit. Page Department of Important: If any injury or	21. Signature of Futteral Service Lic	onsee		Tarr	ing-		Fune	eral Ho				
	23a. Part1. Enter the disease, or co	mplications that causad	ne death. Do no								Approximate Interval Batween	
Physician	shock, or heart failure. List only one cause on each that. Immediata Cause (Final disease or condition A EASTANC BREAST CANCER.										Onset and Death	
/Medical										11 YEAR	5	
Examiner	resulting in death)		Due to (or as a co							1		
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X 68760 entificete be ding physicie se es the bu	resulting in death) Last	-		,						i		
Box 68 leath certifice ettending profess to describe the certifice control of the certification		d								1		
the electric head for the electric head for ysic	Part II. Other significant conditions	contributing to death but	not resulting in	the undarlying	causa g	iven in Part I.		23b. Did	tobacco us	e contributa t	to the cause of de	ath1
Ph de by Jetsec								10	Yea 218	No 3□Pro	obably 4 Unk/	10W
Records, he law requires the hes been signed ge 2 should be d									an autopsy	24b. W	Vere autopsy findin	gs
The law require the less been signed begge 2 should Completed								реп	ormed?	C	ompletion of cause death?	ŀ
The law ete hes bege 2 s								10	Yes 2001	No 1	☐ Yas 2☐ No	
VITAL PICIAN: The certificete irector, peg	25. Was case raferred to medical					26. Piaca	of Daath	(Check only	one)			-
Of VIta Physician: this certific ral director.	examiner? 1 Yes 2 No	Hospitai: 1 ☐ Inpatien	t 2 ER/Out	patient 3 C	O AO	ther:		10		Other (Speci	ify)	
0 5 5 5	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Data of Injury (Month, Day	28b. Ti		28c. inju	ury at ork?	2	8d. Dascribe	how injury o	occurred		
	2 ☐ Accident investigat			М	1[Yas 2 1						
DIVISION or Attending is after deeth. Director: After din by the fune ertification	3 Suicide 6 Could not datarmine	28a. Place of Injurbuilding, etc.		m, straet, facto	ry, offica		2	28f. Location (City or To	Street and I wn, State)	Vumber or Rui	ral Route Number,	
DIVISION C To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: Affert completely filled in by the funera Medical Certification:		hyalclan: To the best of eminar: On the basis of e										
the H thin 24 of the Fi	100	and manner state					5000176	at the time,				
To To	29b. Signature and title of certifier	run	no	_ 2	Sc. Sen	3/77	75			ST / 2		
0			n # 55 : -		7/1	- Ans	1-4-	2	(AC)		,	
\mathcal{S}_{i}	30. Name and appress of berson wh	acompleted cause of de	ath (Item 23a) (T	ype, Print)	Are	STUN	111	mar	4 LAN	D 3	1047	
State Registrar	31. Date filed (Month, Day, Yeer)	32. Registrar	's Signature	6	,		(1			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Helen Marie Brown August 10, 1999 03:50am 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Continuum Care Sykesville Carroll 8. Dete of Birth (Month, Day, Year) Jan 31, 1913 If Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) Deys Months Hours Min 1□ M 20 F 86 Yrs. Maryland 218-28-8633 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo if Yes, Give Yaer or Datas: Wes Decedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowad 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Department Store Sale Clerk 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middla, Last) Hayden Sylvester Peregoy Carrie Marie Nebel 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Mr. Ronald E. Brown (son) 3905 Walt-Ann Drive Ellicott City, MD 21042 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Burial 2 Cramation 3 Ramoval from Stata 8/12/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel (Box 195) 21. Signeture of Funeral Service Licensee Suan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroschatis Coranny Vicato Diane Immediate Cause (Final disaese or condition resulting in death) Sequentielly list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Causa (Disaesa or injury Due to (or es e consequence of) that initietad evants resulting in deeth) Lest Due to (or es a consequance of) Part ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? Malti - Infort Denentin 1 Yea 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availebla prior to complation of causa of daath? 24a. Was en eutopsy performed? 1 Yas 2 PNo 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Steta

Director

Funeral

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MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f abov other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haalth end Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once.

altimore, Maryland 21215-0020

with the Maryland

Examiner

attending physician and for use as the burial-transit USB BS this certificate funeral al or Attending F s after deeth. After

Division of Vital Records.

Hospital 24 hours

To the F within 2

Physiclan/Medical PV Completed P Certification:

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25.	Wes	cese	referred	to	medice
	exem	iner?	1		
	101	/es	217 No		

27. Menner of Death 1 PNetural

28a. Dete of Injury (Month, Dey Year) 5 Pending 6 Could not be determined

Hospitel: 1 | Inpatient 2 | ER/Outpetlent 3 | DOA 28b. Tima of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Spacify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifia (Check only one)

2 Accident

4 ☐ Homicide

3 ☐ Sulcide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifier Ilolot d. Mon, mo 29c. Licanse number

072882

29d. Deta signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

30. Nama and addrass of parson who complated causa of daeth (Item 23a) (Type, Print)

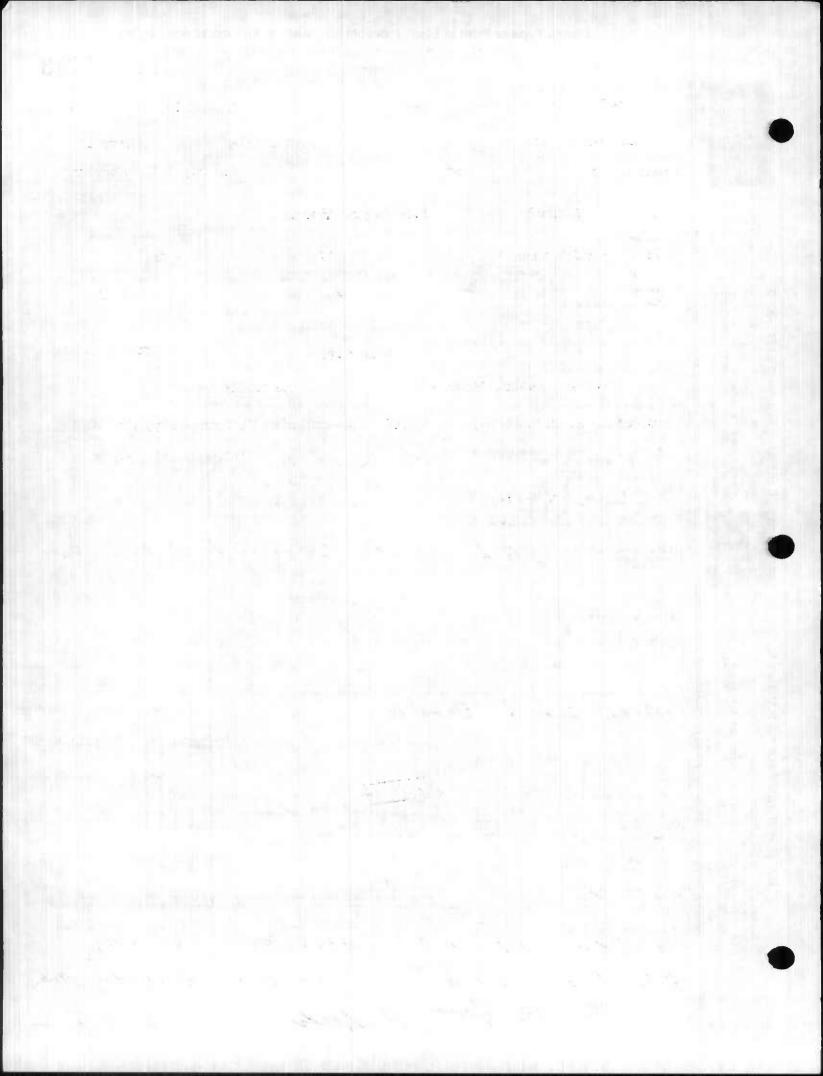
Robert L. Moss / 114 Basiners Center Dive Reinforders, Md.

State Registrar

edical

31. Dete filed (Month, Pay, Year) AUG 1 1 1999

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 milu 1:05 Am Bevard 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Carroll Lutheran Village Westminster Carroll 8. Dete of Birth Apr 10, 1904 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Deys 1 M 2 SF Months Hours Mary land 95 Yrs 212-74-6912 Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Westminster Carroll 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 300 St. Mark Way 21158 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 8 18. Mother's Neme (First, Middle, Meiden Sumeme) 17, Fether's Neme (First, Middle, Last) John Franklin Hanson Anna Grace Smith 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mrs. Martha Streaker (Daughter) 1150 West Friendship Road Sykesville, MD 21784 20b. Plece of Disposition (Neme of cemetery, cremetory or other place)
Wesley Chapel Cemetery 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Deuriel 2 Cremetion 3 Removel from State 8/11/99 Eldersburg, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Haight Funeral Home & Chapel (Box 195) 21. Signeture of Funerei Service Licensee rianos Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth 46 days Immediate Ceuse (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or as e consequenca of): Due to (or es e consequenca of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CHRONIC LYMPHOCYTIC LEUKEMIA 24b. Were eutopsy findings eveileble prior to ADULT ONSET DIABETES MELLITUS 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury (Work? 27. Manner of Deet 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

Examiner Examiner

/Medical

Important: If it any injury or o

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

I is marked other than "natural", or frame 23a or trsumetic event, the Mexical Examiner must be

Peges 1 and 2 should be filed within 72 hours after deeth nent of Health and Mentel Hygiena. Instit if them 27 is marked other than "natural", or theme 23 mry or other traumatic event, in Mentel Experiment must you

with the Marylend

The law requires that the death certificate be asscuted physician and the burial-transit 98 950

Physician/Medical

Completed

Be

Certification: To

edical

or Attending Physician: after death. Director: After this cartifice 24 hours aft Funeral Di

Division of Vital Records, P.O. Box 68760,

1 Yes

6 Could not be 4 Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier 29b. Signeture end title of certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the ceuse(s) end menner as stated. 2 Medical Exeminer: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and dua to the cause(s) end manner stated. 29d. Dete signed (Month, Dey, Year) 29c. License number

Rd. WestminsterMD

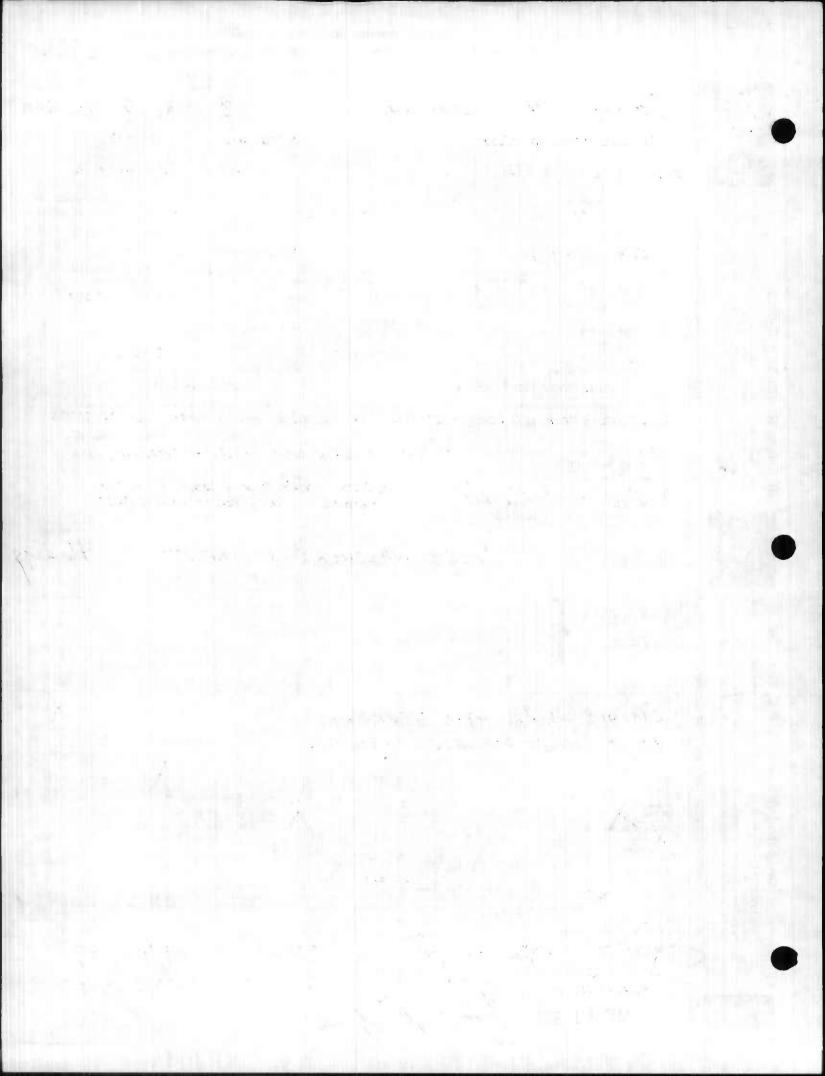
eted cause of death (I)em 23a) (Type, Print)

Tames L. Forsberg 912 Washin

31. Dete filed (Month, Dey, Year) AUG 1 1 1999 32. Registrar's Signeture

State Registrar

To the Hosp within 24 ho To the Fune completely fi



State Registrar

31. Date filed (Month, Day, Year) 1999 **AUG 16**

29b. Signature and title of pertifier

32. Registrar's Signature

m who completed cause of death (Item 23a) (Type, Print)

onte

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Dete signed (Month, Day, Year)

August 14, 1999

To the I within 2 To the I

1,15 11,11 99-4597-001 CJ Patsy Jean Bolyard

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental HygieneQ Q Certificate of Death

26686

Physician
/Medical
Examiner

PATSY JEAN BOLYARD

1. Decedent's Name (First, Middle, Last)

2. Data of Death August

3. Tima of Death 1999 02:39 PM. 4c. County of Death

1949

USA

Allegany

9. Birthplaca (Stata or Foreign Country) West Virginia

10d. Inside City Limits 1 ☐ Yas 2 No

4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) .6 mile south of Legislative Road Barton Route 36 If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July 30, 1 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🂢 F 236-78-5263 50 Director Usual Rasidence of Decedent with the Marylend r 28a-f show inotified at 10a. Stata 10b. County 10c. City, Town or Location Directo MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or flams 23s or the Medical Examiner must be 15944 Maryland Highway 21561 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yas 2 🔯 No If Yas, Give Year or Detas: 1 ☐ Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Be Completed Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) if Item 27 is marked o Otis A. Metcalfe Virginia M. Spitzer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Stanley Bolyard/Husband 15944 Maryland Highway other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Deta Aug. 1999 1 Burial 2 □ Cramation 3 □ Removal from Stata 10 6 Department of Important: If any Injury or page 4 ☐ Donation 5 ☐ Othar (Specify) Potomac Memorial Gardens 21. Signature of Funarel Sarvice Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. **Physician** /Medical Immedieta Causa (Final disaasa or condition rasulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last pud Dua to (or as a consequence of) Box 68760. physician Physician/Medical the Due to (or as a consequence of) 8 esn. for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Completed by has page 2 certificate funeral director, Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) Medical Certification: To 1X Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Tima of 5 Pending investigation 1 Natural 1 Yes 2 1 No death. 199 2:30 PM s after death 6 2 X Accidant the 6 Could not be determined 3 ☐ Suicide Place of injury - At hon building, atc. (Specify) 28a At home, tarm, street, factory, office 3 4 ☐ Homicide filled in To the Hospital of within 24 hours at To the Funeral D completely filled is street 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

25 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. August 7, 1999 addrass of person who completed cause of death (Item 23a) (Type, Print) and

(res

32 Begistrar's Signatura

14. Race - American Indian, Black, Whita, atc. Specify: White 16b. Kind of Business/Industry Nursing Home Swanton, MD 20c. Location - City or Town, Stata Keyser, WV 26726 Keyser, WV Approximete Intarval Batween Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to complation of causa of death? 24a. Was an autopsy performed? 12 Yas 2 □ No 1. Yas 2□ No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Scene 28d. Describe how injury occurred

28d. Describe how injury occurred

Driver of water vehicle

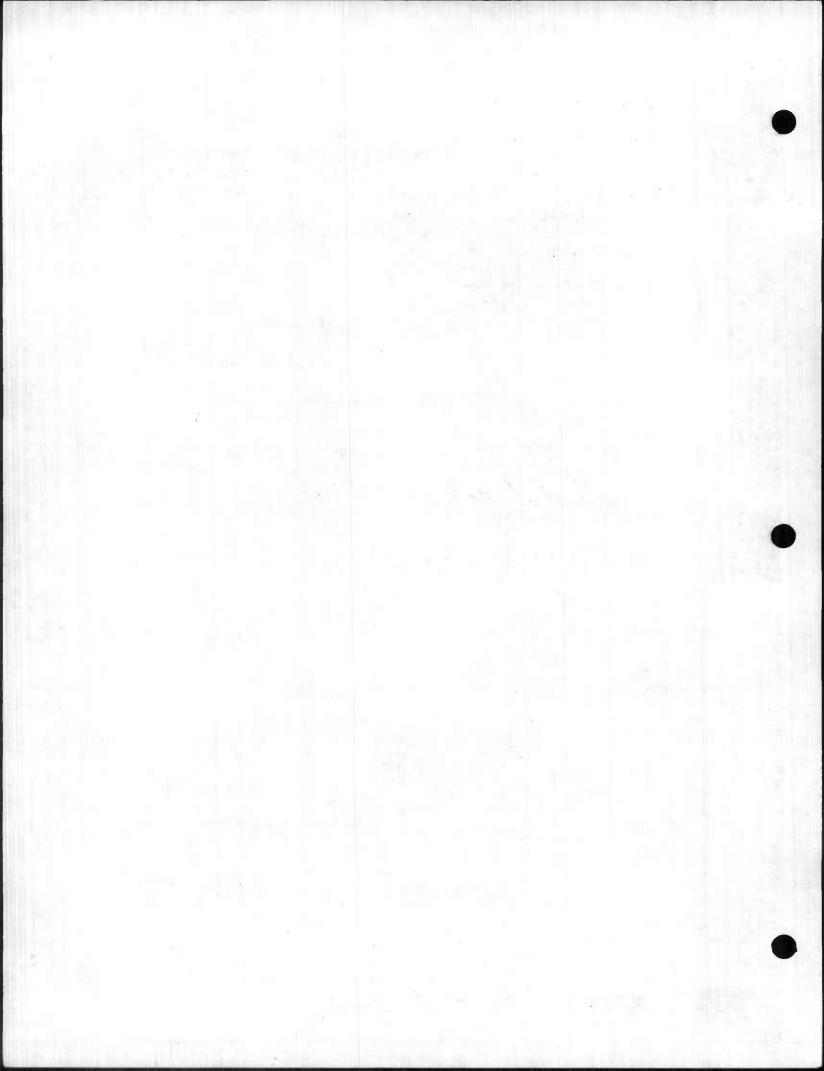
28t. Location (Street and Number or Rurel Route Number,
City or Town, State) motor vehicle another white Md -ton.

Registrar

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State

June 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 99 26687

						rtificate of			Reg. No.						
	1. Decedent's Neme (Fire	rst, Middle, Li	nst)					2. Date of De Month		3. Time of Death					
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xaminer	4a Facility Name (If not i	institution, gi	ve street and nui	mber)			4b. City, Town, o	or Location of Death	4c. Count	y of Death					
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ž m		. County		10c. C	ity, Town or Lo	ocation				10	Dd. Inside City Limits				
Tor Tor	MARYLAND	ALLE	GANY		CUMB	ERLAND					1 ☐ Yes 2X No				
be notified Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Count	ry?				
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10	JAMES BOGG	GS					TACY R	OBINETTE							
To Be C	19e. Informant's Name/F	Relationship	(Type, Print)					Rural Route Numbe	er, City or Town	, Stete, Zip	Code)				
	NANCY POST		DA	AUGHTER	P.O.	BOX# 669	CORNW	ALL NEW Y	ORK 1:	2518					
5	20a. Method of Disposition 1 Durial 2 Cre 4 Donation 5 December 2	emetion 3		01-1-	cemetery, crei	osition (Name of metory or other p MORIAL C		AUG 16 19	20c. Location 99 CUMI		m, Stete D MARYLAND				
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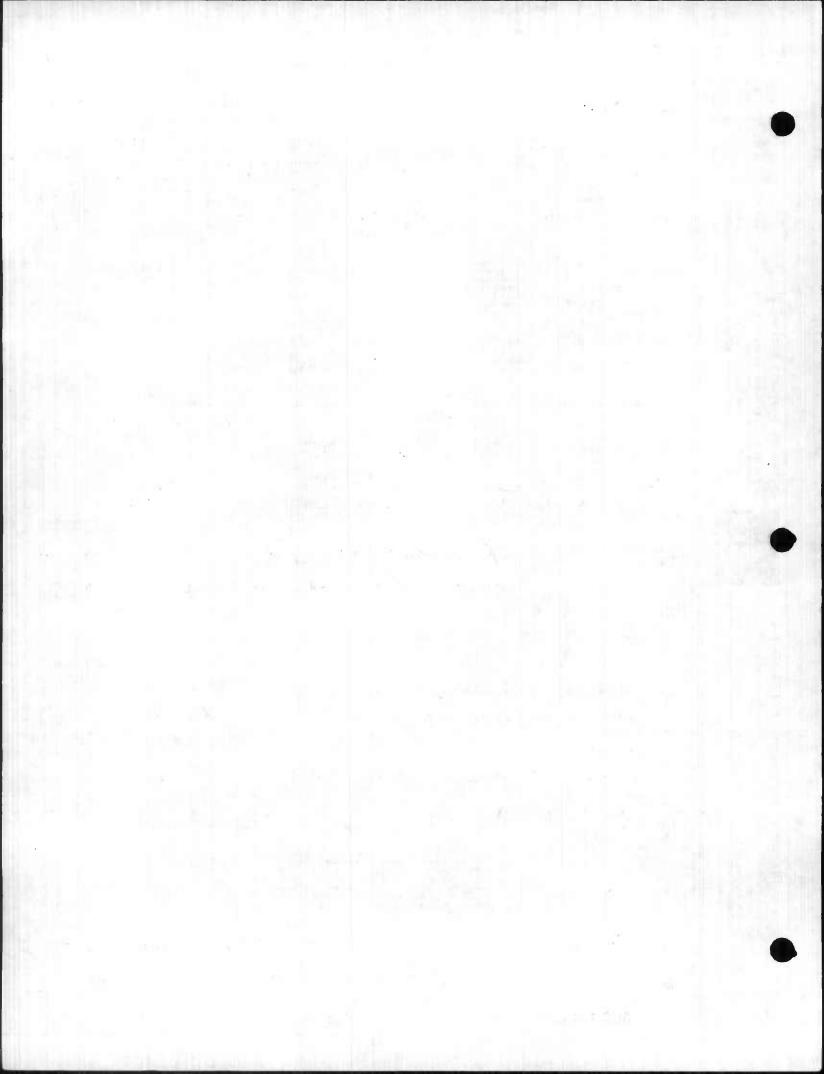
State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 1999

Some



State of Maryland / Department of Health and Mental Hygiene 9 9 26688

Certificate of Death

			Cer	tificate of i	Death	R	eg. No.	2	
	1. Decedent's Nema (First, Middle, Las	st)				2. Dete of Dea Month	th Dey	Yeer	3. Time of Deeth
ysician Medical	Orem Franklin	Carroll				August			0505
kaminer	4e Facility Neme (If not institution, give	street and number)		4	b. City, Town, or Lo	ocation of Death	4c. Count	ty of Death	
	Fallston General	Hospital			Fallston		Har	ford	
neral	Social Sacurity Number 6. S	ex 7. Age (In	yrs. lest birthday)	If Undar 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey	Year	9. Birthple	eca (Stata or Foraigny)
ector	218-16-6526 Usuet Residence of Decedent	0XM 2□ F 7	7 Yrs.	Months Boys	110013	Feb. 27	, 1922	Maryl	and
#	10a. Stete 10b. County	100	City, Town or Lo	cation				10	d. Inside City Limits
notified at rector	MD Harford	3 /	Aberdeen						1 Tyes 2 No
irec	10e. Street and Number			10f. Zip Code		1	0g. Citlzen of	What Count	ry?
al Di	303 Graceford Dr	rive		2100	1		U.S.	Α.	
uner	11. Maritei Stetus	12. Was Decedant Ever	in U,S. 13. \	Ves Decedent of H	lispanic Origin? (Sp an, Mexicen, Puerto	ecify Yes or No-		ce - America	
1	1 Never Married 2 Marriad 3 Widowed 4 Divorced	Armed Forcas? 1 [XYes 2 □ No If Yes, Give Yeer or Detes 94]		Yas, specify Cube	Specify:	Hican, atc.)	Speci	eck, White, e ^{ify:} Whit	
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0 0	Charles F. Carro	011			Helen	Hummer			
Tan I	19e. informent's Neme/Reletionship (19b. Meilin	a Address (Street	end Number or Rur		r. City or Tow	n. State. Zip (Code)
train.	Kellie C. Hallq				ne, Aberde			21001	
the	20e. Method of Disposition			sition (Neme of netory or other place		Date Date	20c. Location		
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d for	Pert II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderiving cause giv	ren in Pert i.	23b. Did to	obacco use c	ontributa to	the cause of death
Physician/	^				F 1 F 1 W 1 W		(ee 2□ No		
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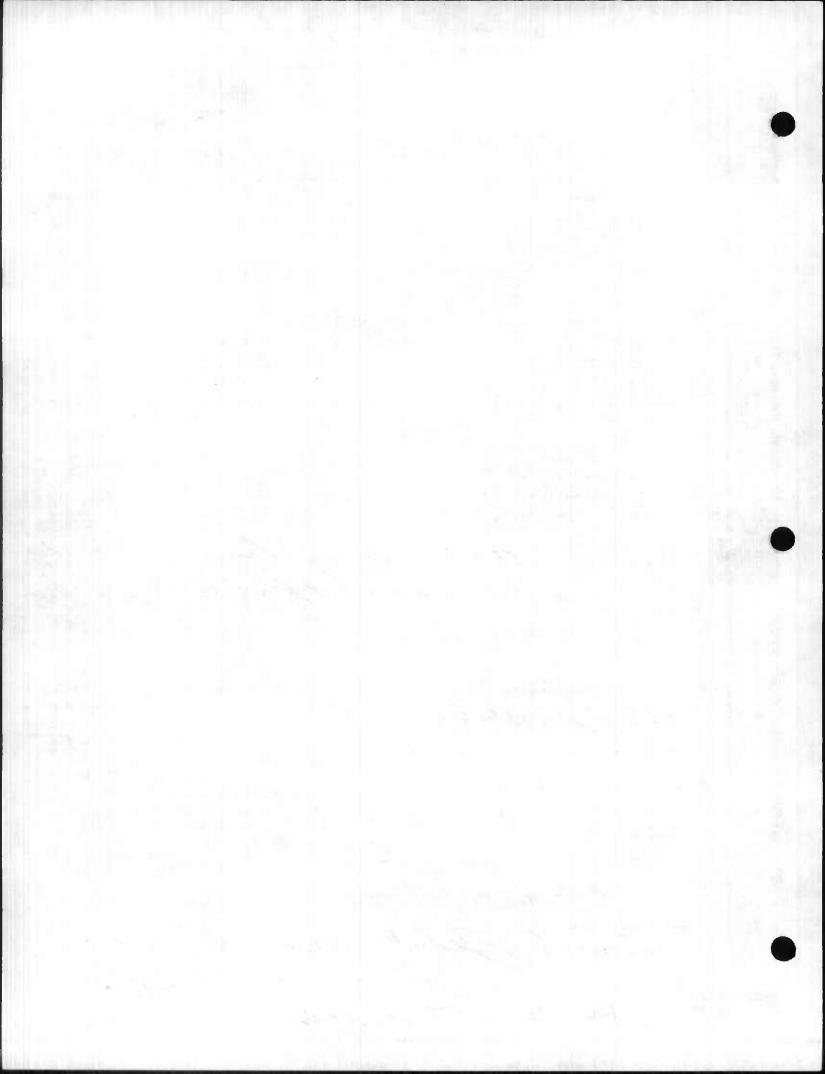
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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 8, 1999 Thomas Monroe Chaney 6:35 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1₩ 2□ F Hours Months Yrs. 75 27, 1924 Maryland Director 212-20-6098 Jan. Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Carroll Union Bridge Directo "natural", or Items 23s or 28s-f 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 421 Quaker Hill Rd. 21791 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 ☐ No 14. Race - American Indian, 11. Maritel Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: 1943-45 à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) administrator of operations airplane mfg. permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If flem 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Thomas M. Chaney, Sr. Betty Stull 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Chaney/ cousin 2500 Driftwood Ct. Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 6 Prospect Cemetery 8/11/99 Mt. Airy, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Hartzler Funeral Home garine an E. Broadway Union Bridge, MD 21791 23a. Part1. Entar the disease, or complications that cause the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each inn. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examine The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to for es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed peed hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, Be 25. Was case of 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 DiNetural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) AUG 1 0 1999 31. Date filed (Month, 32. Registrar's Signeture State

Registrar



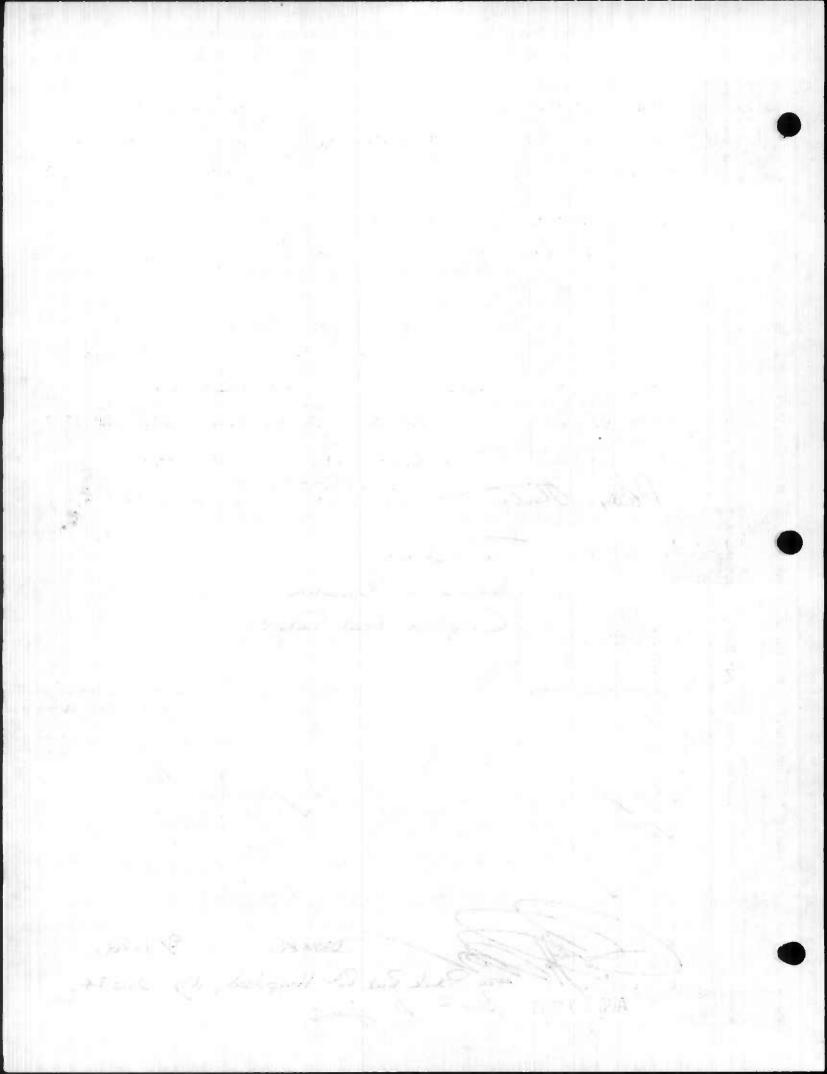
State of Maryland / Department of Health and Mental Hygien ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month SYDNEY LATIMER CARLISLE 9, AUGUST 1999 9:20AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Nursing & Rehab. Ctr. Westminster Carroll 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Securify Number 9. Birthplece (State or Foreign Country)
Maryland 8. Dete of Birth (Month, Dey, **Funeral** t**©** M 2□ F 97 Yrs 213-05-9017 Director 1902 14 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Carroll Hampstead 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? with 5109 A Blackrock Road death v 21074 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American indien, Black, White, etc. 11. Maritel Status filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: White 3 CWidowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Baltimore Elementery/Secondary (0-12) College (1-4or 5+) 8 Supervisor Transit System nd 2 should be filed walth and Mental Hygier 27 Is marked other the traumatic event, the Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Pages 1 and 2 should Wallace Carlisle Lily McLaughlin Sydney 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Depertment of Health a important: if item 27 Is any injury or other tra Geneva V. Long - Niece 5109 A Blackrock Rd., Hampstead, MD 21074 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetery or other piece) Dete 20c. Location - City or Town, Stete 1 ➡ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8-12-99 Woodlawn, MD Woodlawn Cemetery 21. Signetur Funeral Service License 22. Name end Address of Fecility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onsef end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner Al Eleimer > The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lesf pue buriel-trar Due to (or es e consequence of): P.O. Box 68760, ettending physician for use as the burie Physician/Medical Due to for es e consequence of) ed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Nonknown Records, δ Completed 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed? peed certificate has 2 1 No Division of Vital 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlenf 3 ☐ DOA 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) After this 27. Menney of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury of Work? 1 Netural 5 Pending Investigation death. 2 Accident 1 ☐ Yes 2 ☐ No in by the f ofter death Director: 3 Sulcide 6 Could not be 28e. Plece of Injury - Af home, ferm, streef, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C 1 Cartifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.
2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) edical 29a, Certifier completely (Check only one) 29b. Signeture and title of country 29c. License number 29d. Dete signed (Month, Dey, Year) 038489 30. Name and address of p 23a) (Type, Print) ampstrad 4500 Peter Uggowit 32. Registrer's Signeture State

Registrar



State of Maryland / Department of Health and Mental Hygien Q 26691 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ODESSA JEWELL CONRAD 12, 1999 0740 AM August /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Director 214-07-2125 MAY 29 1917 W. VA. Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 209 DAVIDSON STREET 21502 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours effer Hygiene. other then "netural", or ite 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w.
Department of Heelth and Mental Hygiens, Important: If Nem 27 is marked other the enty Injury or other traumetic acceptance. 8 HOME MAKER HOME MAKER 17 Father's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES EDWARD **JEWELL** SARA CLINE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) PAULMER CONRAD HUSBAND 209 DAVIDSON STREET CUMBERLAND MARYLAND 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition

↑□ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) LYBARGER CEMETERY AUGUST 14 1999 MADLEY, PA. 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. 21. Signature of Funeral Service Lice 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ARDIDGENIC TWO DAYS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner MYOCARDIAL (SCHOMIA TWO DAYS physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): TEN YEARS Box 68760 CORONANY MATERY DISCASE Physician/Medical Due to (or as a consequence of) 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25 No 3 Probably 4 Unknown DIABETES Records, þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation Injury 1 Natural death. 1 Yes 2 No ne Hospital or Attendi n 24 hours ettar death. Ne Funeral Director: A pietaly filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of our 033417 12 loca ous August 12, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

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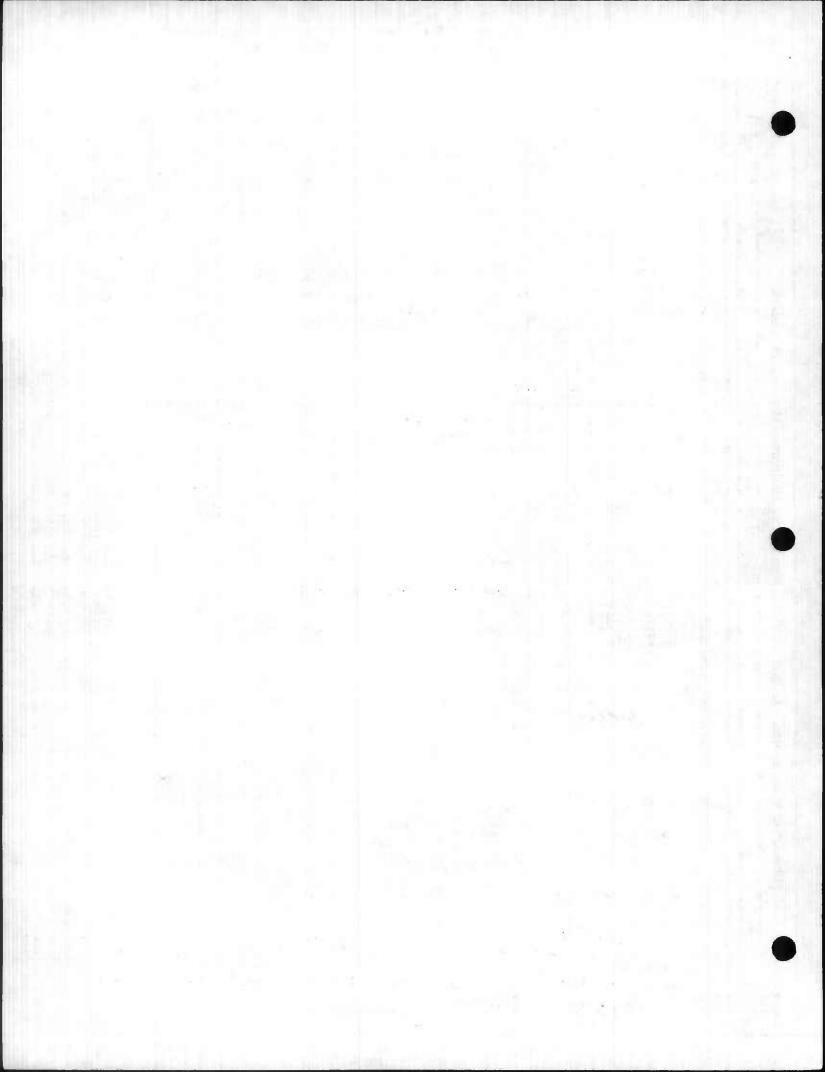
JAMES R MOEN, MO

31. Date filed (Month, Day, Year) AUG 1 3 1999

32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygieneg

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Physician	1. Decedent's Neme (First, Midd							1	2. Date of De Month	Da		Yeer	3. Time of Death
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Examiner	4e Facility Neme (If not institution		u <i>mber)</i>				OAKLA		cation of Deet		GARR		
	114 JASPER RIL 5. Social Security Number	6. Sex	7 Ace /In v	rs. last birthde	If Under 1	Year		Carlo Mariano	8. Date of Bi	dh			lace (State or Foreig
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or 2	10e. Street and Number				10f. Zip C							Vhat Coun	try?
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To the Funerel Director: After completely filled in by the funer medical Certification:		ng Physician: To the Examiner: On the and ma	ne best of my libasis of examinner stated.	knowledge, de ination and/or	eath occurred at investigation, i	t the t	ime, date an opinion, dee	d plece, a	and due to the	ceuse(s	s) and ma od place,	inner as s and due to	tated. the cause(s)
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	30. Name and eddress of person S. SAVOPOULOS,		RT. 1	tem 23a) (Tyj BOX 5		ERR	A ALTA	, WV	2676	4			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** AUGUST 3,1999 Norma Elizabeth Davis 5:15 A.M. /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 258 F 232-26-3852 Yrs Director Jan. 28, 1923 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow avant, the Medical Examiner must be notified at 1 Yes 2 No Director WV Hampshire Romney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herns 23a 306 School Street 26757 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental hyglene. Important: If itam 27 is merked other than "natural", or item any injury or other traumatic avant, the Medical Exerciper page. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking Office Manager 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Be Wesley Talmadge Smith Iva Agnes Rogers Lo 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen E. Osentoski Rt. 2 Box 391, Keameysville, WV 25430 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08-07-99 4 ☐ Donation 5 ☐ Other (Specify) **Ebenezer Cemetery** Romney, WV 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Baldwin Funeral Home, Inc WV Funeral Director #1320 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. P.O. Box 1940, Romney, WV 26757 **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MULTIPLO MYELOMA - MONTHS Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yaa 2 No 3 Probably 4 Unknown Records, p Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 D No 1 Yes 2 No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; p. Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Umpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 29a. Cartifier (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D50844 5 PHYSICIAN .1999 s of person who completed cause of death (Item 23a) (Type, Print) 912 ANON DRIVE OUNGERLAND MP 21502 LOVERY JR. MAS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 1999 Registrar

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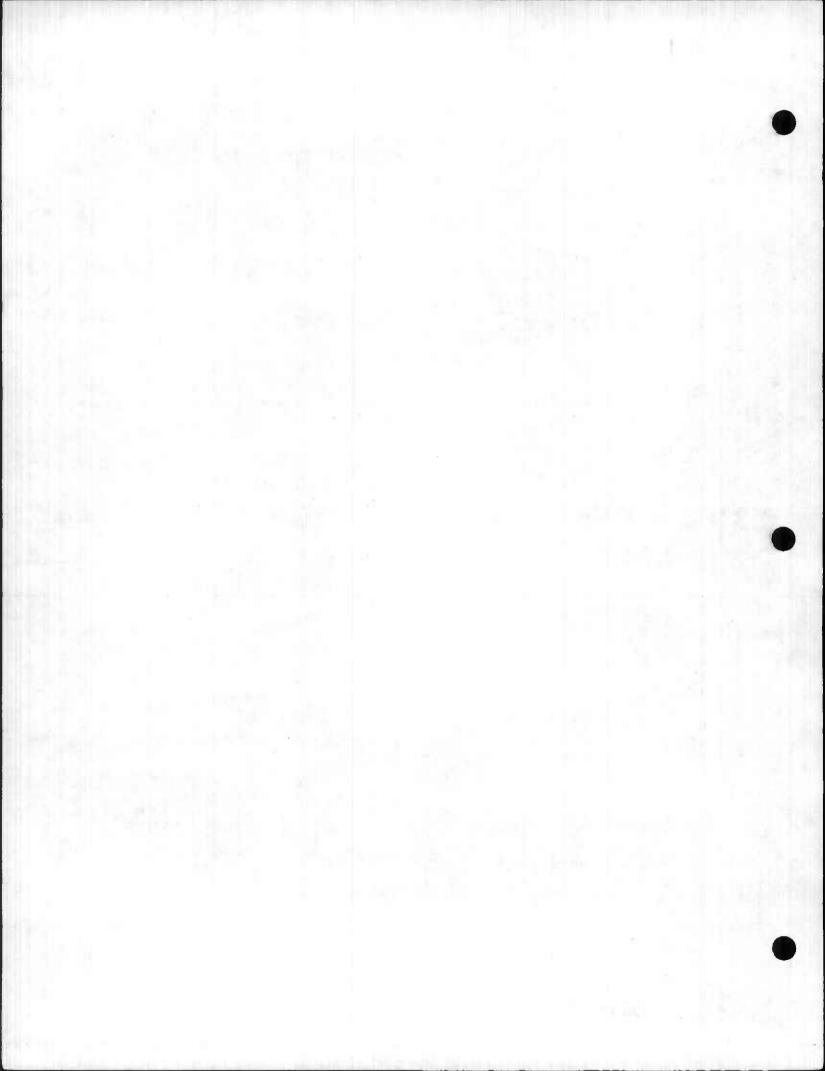
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Amengled # 10c, nhs Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 8/10/94, Allegany County State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dev Yea **Physician** FRANK WILLETTS DUNCAN, JR. 5 AUGUST 1999 1400 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND SACRED HEART HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 1) JULY 30 5. Social Security Number 6. Sex 1XIM 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1933 Months Days FROSTBURG Yrs. 65 Director 220 30 8178 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23s or 28s-f show must be notified at 14 Yes 2 □ No 152 CENTER STREET Frostburg MARYLAND ALLEGANY 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? à than "natural", or hame 23a the Medical Examiner must b U.S. 152 CENTER STREET 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian, Bleck. White, etc. hours after 1 K) Yes 2 □ No If Yes, Give KOREAN Year or Detes: CONFLICT 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) BARTENDER AMERICAN LEGION 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be lit ment of Health and Mental H ant: If Item 27 is marked off 88 NOVELLA STEVENSON FRANK DUNCAN 2 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if Item 27 is any injury or other trau 2008. 152 CENTER ST., FROSTBURG, MD 21532 MAUREEN DUNCAN / WIFE 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Durial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) 8/7/99 FROSTBURG, MD FROSTBURG MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** /Medical Immediate Cause (Final METASTATIC BRAIN DISEASE diseese or condition resulting in death) month Examiner Due to (or as a consequence of): Examiner that the death certificete be executed physician and is the burial-trans Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 68760 Physician/Medical Due to (or as e consequence of): Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Records. þ should 24b. Wera autopsy tindings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 (XNaturat 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation n 24 hours after deeth.

Funeral Director: A jetely filled in by the fu 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 D21244 **AUGUST 6 1999** 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) rostburg MD 21532 rostburg 101 72. Registrer's Stigheture State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month AUGUST 12, 1999

Physician /Medical Examiner

VIOLET ELMYRA DeVELBISS 4a Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL

4b. City, Town, or Location of Death CUMBERLAND

1410 PM 4c. County of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Intervel Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

MARYLAND

ALLEGANY

Bleck, White, etc.

Funeral Director

28a-f show must be notified at Director 8 therms 23a Funeral "natural", or 4 Completed

72 hours after permit. Pages 1 and 2 ahouid be filled within 72. Department of Health and Montal Hygiene. Important: if Item 27 is marked other than any Injury or other.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Physician /Medical Examiner

Examiner physician and s the burial-trans Physician/Medical signed by t by Completed peen page 2 s Be Certification: To this After thi

that the death certificate be executed or Attending after death. Director: Aft To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 2

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 1□ M 27 F 79 214-46-3257 NOV 26 1919 Usual Residence of Deceden 10a. Stete 10c. City, Town or Location 10b. County RIDGELEY MINERAL W. VA. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 26753 RFD# 1 BOX# 156 (WILEY FORD) 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian. 11 Marital Status 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2√No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PRINCE WILLIAM CO. VIRGINIA CLERK 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAZEL TASKER HARRY B. ELLIFRITZ 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND RFD#1 BOX#156 RIDGELEY, WEST VIRGINIA 26753 CURTIS VANCE DeVELBISS 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) POTOMAC MEMORIAL GARDENS AUG 14 1999 KEYSER, W.VA. 21. Signatore of Funeral Service Licera 22. Neme end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. end 404 DECATUR STREET CUMBERLAND MARYLAND 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Fine) monary diseese or condition resulting in death) Due to (or as a so quence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 22 No 24e. Was en eutopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 29e. Certifier Example 1 (a) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stelled. 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end address of person who completed use of death (Item 23a) (Type, Print) WAGONER 925 DR GARY L. BISHOP WALSH DRIVE CUMBERLAND MARYLAND

28c. Injury at Work?

1 Tes 2 No

State Registrar

MS

edicai

Σ

31. Date filed Month, Day, Year 1999

1 Yes 2 No

27. Menner of Death

1 Desturel
2 Accident

3 ☐ Sulcide

4 | Homicide

32/Registrer's Signeture

Hospitel:

5 Pending Investigation

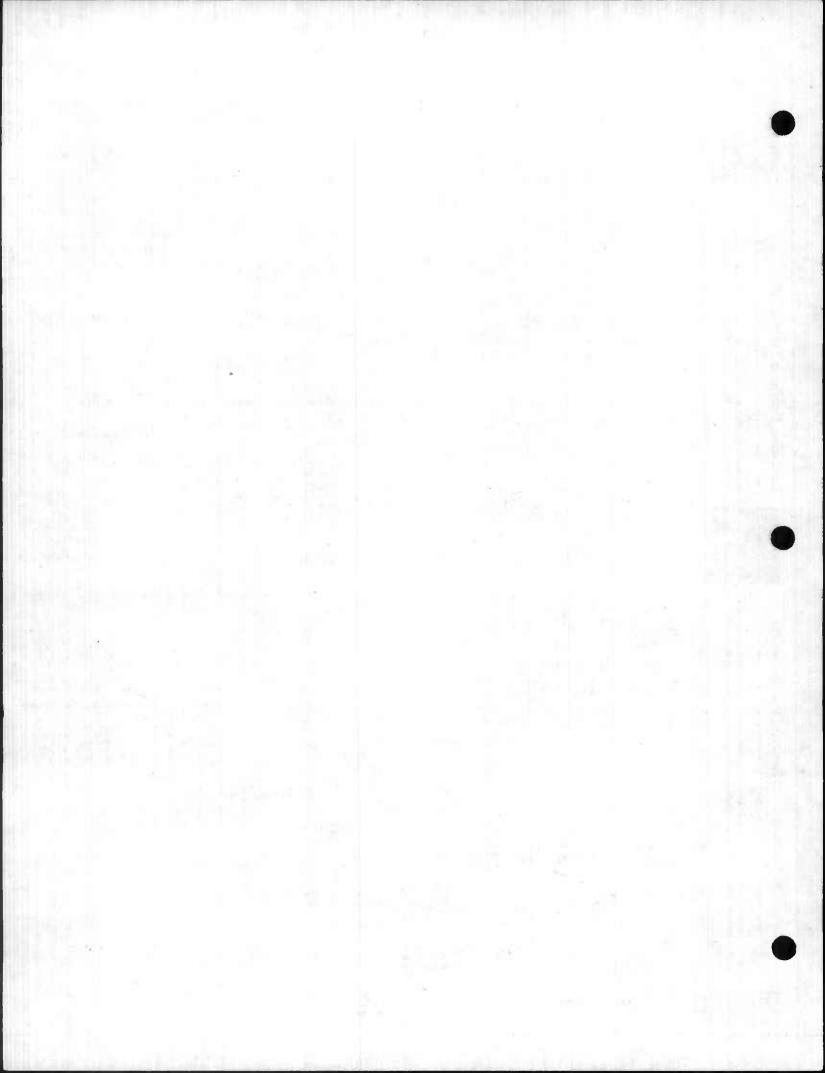
6 Could not be determined

1/ Impatient

28a. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of Injury



State of Maryland / Department of Health and Mental Hygiene 00 000

		1. Decedent's Neme (First, Middle, Last)			001	tificate of	Doutil	2. Date of De		3. Time of Death
Physic /Medi		ELIZABETH SOPH	IA DAVI	S				AUGUST	Day Year 12, 1999	1315
Exami		4a Facility Name (If not institution, give s	treet and number)				4b. City, Town, o	r Location of Death	4c. County of Di	eath
<u> </u>		SACRED HEART HO 5. Social Security Number 6. Sex		Observed to a	A E ! AE - 4 . 4 . 4 . 4 . 4 . 4 . 4 . 4 . 4 . 4	If Under 1 Yea		ERLAND	ALLEG	
Funeral Director			M 27 F 89	(In yrs. las	Yrs.	Months Day			8,1910 NE	Birthplece (Stele or Foreign Country) W MEXICO
Maryland of ehow	tor	10a. State 10b. County MD ALLEGAN			Town or Loc BERLA					10d. Inside City Limits 1 ☐ Yes 🏖 No
after deeth with the Marylan or Name 23e or 28e-f show priver must be northed at	Funeral Director	10e. Street and Number 14503 N. BEL AD	R DRIVE	, S.	W.	10f. Zip Code 215	02		10g. Citizen of What U.S.A	
5-0020 72 hours after deeth with the Maryland natural; or Nems 23s or 28s-f show dess Examiner must be notified at	by	11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. Was Decedent Ender Armed Forces? 1 Yes 2 Note of Yes, Give A Year or Dates:			Vas Decedent of Yes, specify Cu		(Specify Yes or No orto Rican, etc.)		merican Indien, hite, etc. WHITE
Par digital	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	cation completed) College (1-4or 5+		(Give I life. D	ent's Usual Occiond of work don to NOT use retire	e during most of weed)	orking*	16b. Kind of Busines	ss/Industry
yiand 2121 build be filled within Mental Hyglens. sirked other than sitic event, or the	To Be C	17. Fether's Neme (First, Middle, Last) FRED SCHULLER		1			18. Mother's N	eme (First, Middle, ERINE O	Maiden Sumeme)	10.2
IOCE, Maryia ges 1 and 2 should t of Health and Men If Hem 27 la marks or other traumatic		19a, Informant's Name/Reletionship (Type KATHRYN BROWN /	oe, Print) / SISTER		and the same of				er, City or Town, State	a, Zip Code) D, MD 21502
2 % 8 % B		20a. Method of Disposition 1 Surial 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	emovel from State	сел	netery, crem	sition (Name of setory or other p		Date 8/16/99	20c. Location - City CUMBERLAN	
Baltin permit. Pa Departmen important: eny injury page.		21. Signature of Funeral Service License	church)	UE		FUNERAL	HOME, P.		502
Physician		23a. Part1. Entar the disease, or complice shock, or heart failure. List only on	cations that caused to e cause on each line	ha deeth.						Approximeta Interval Batween Onset and Death
/Medical Examiner	ner	Immediata Cause (Finel disease or condition resulting in death) s	MYEL		S s consequ		VE DIS	'tAST		MONTHS
(68760, rifficete be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			s a consequ					
deeth cerr e ettendin od for use	clany	d.								
P.O. hat the detache	y Physician/M	Part II. Other significant conditions conf	ributing to death but	not resulti	ng in the un	derlying cause (jiven in Psrt I.			uta to the cause of death? Probably 4 Unknown
Per la	Completed by							24a. Was perfo	an autopsy 24 mmed?	b. Wera autopsy lindings evallable prior to completion of cause of death?
The It Th								10		1 Yes 2 No
Of VITA Physician: this certific ral director.	o Be	25. Was casa referred to medical examiner? 1 Yes 2 No	ospital:	t 2∏FF	NOutpatient	3 DOA	ther _	eath (Check only of Home 5 ☐ Resi	one) dence 6 Other (S	Specify)
E 6		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day	2	8b. Time of Injury	28c. In		7	how injury occurred	poorty
DIVISION Let or Attending as after death. Let of in by the fune	Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Injur building, atc.		e, ferm, stre	et, lectory, offic	Э	28f. Location (: City or Ton		Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edical	29a. Certifier (Check only one)	ician: To the best of er: On the basis of e and manner state	examination	edge, death n and/or inv	occurred et the estigation, in my	time, date end pla opinion, death oc	ce, end due to the curred at the time,	cause(s) end manner date and place, and o	r as stated. due to tha cause(s)
To the within 2 To the comple	Me	29b. Signeture and title of certifier	40			29c. Lice	nse number		29d. Date signed (M	onth, Day, Year)
6	1	30. Name and address of person who cor	mpleted cause of dea	ath (Item 2	3a) (Type, f	Print)	744/	0.111.0	AUGUST (1999
	te	VINUINIA 6. MAGI 31. Dete filed (Month, Day, Year)	30 JUS W 32. Registrer	9	12 1	TION	PRWE	eumm	MAN!	10 2 cm

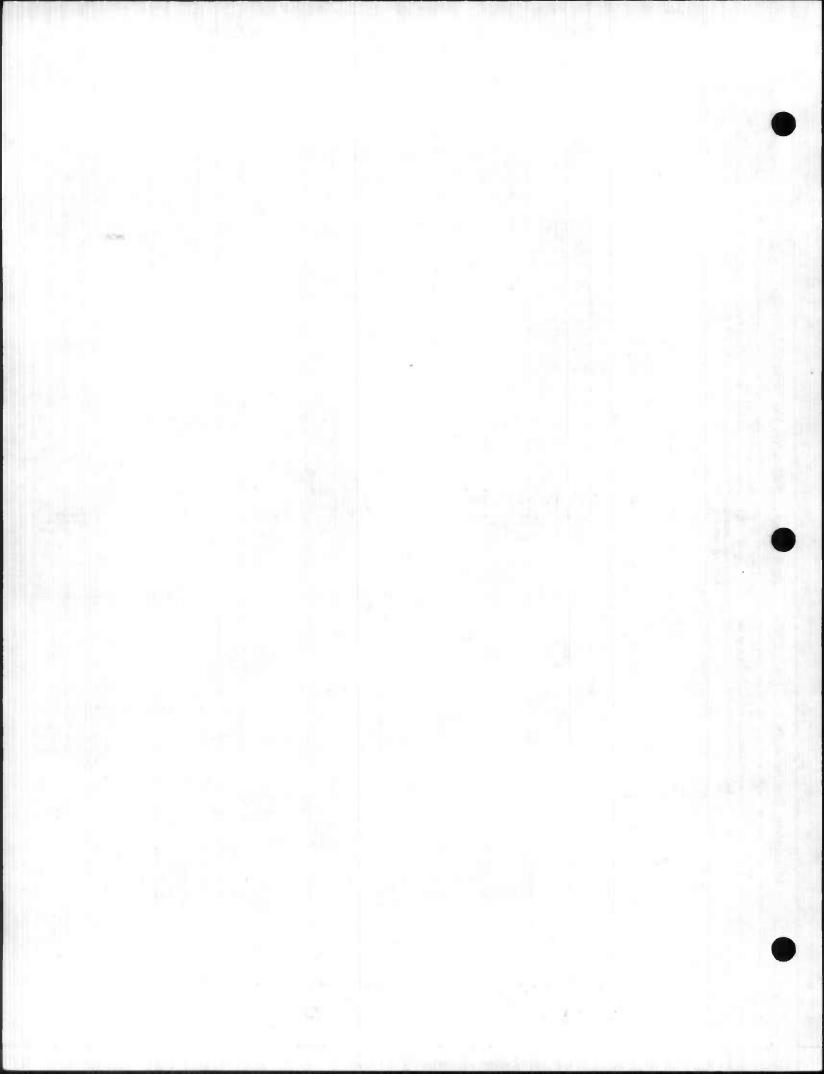
DHMH 16 Rev 6/95

ORIGINAL

1 1 2 V

State of Maryland / Department of Health and Mental Hygiene 99 26697

ce						Ce	rtificat	te of i	Death			Reg. No.	00	20001
		1. Decedent's Name (First, Middle, La	ist)							2. Date of De			3. Time of Death
	Physician	Elmer	Eugene	Fike							Month August	Day 1 1	Year 199	0 00 15 314
	/Medical Examiner	4a Facility Name (If no			imber)			14	tb. City, To	wn, or Lo	cation of Deal	1	inty of Death	the state of the s
4	Examiner				h Stree	+				kland				
-		5. Social Security Num		Sex	7. Age (In yrs.		If Unde	r 1 Year	If Under			_	arret	
н	Funeral	214-32-37		10XM 20F		Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D			nplace (State or Foreign intry)
ш	Director	Usual Residence of De			63						Sept.	27, 19:	35 Ma	ryland
	pu B		Ob. County		10c, City	y, Town or Lo	ocation							10d. Inside City Limits
	ahe da) (T)												1⊠ Yes 2 No
	ith the Marylar or 28a-f show a notified at	MD	Garret	τ		Oaklan	1							
	with the Maryla to or 28s-1 show be notified at Director	10e. Street and Number					10f. Ziş					10g. Citizen	of What Cou	intry?
	death with the Maryland ms 23a or 28a-f ahow mass be notified at	4 S. Fou	rth Str	eet				2155	0			USA		
		11, Marital Status		12. Was Dec	edent Ever in U, proes?	S. 13.	Wes Dece	dent of H	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Amer Bleck, White	
0	or h		2 Married	1 ☐ Yes If Yes, Gi	2 🖾 No		1 Yes		Specify:				a Maria	
05	by	3 □ Widowed 4 [Divorced	Year or E	Dates:		103	263 140	Specif.			Spe	ocity: Wh	nite
21215-0020	should be filed within 72 hours after ad Mental Hygiene. marked other than "natural", or he unratic event, the facilitation To Be Completed by Fu	/015	. Decedent's E	ducation		16a. Dece	dent's Usu	al Occup	ation			16b. Kind o	Businass/I	ndustry
21	hin 7	Elementary/Seconds	only highest gra		1-4or 5+)		DO NOT U		during mos d)	OF WORK	ng			
21	Hygiene. ther then and, in the Comple	10th	ury (0 12)	Compage (1 401 01)		Tru	ick D	river			Mar	nufact	urino
D	be file d othe event,		rst, Middle, Last)							(First, Middle	, Maiden Sun		uring
a	Mental Mental arked o artic even	Walter	Gordon	Fike					No	ra H	rances	Knov		
5	2 should and Men s marke sumatic	19a. Informant's Name				19b Maili	na Addres	s (Street				ber, City or To	wn Stata Z	in Code)
Maryland	0 5 6 5	Tammy Wel					-					d. 215		, , , , , , , , , , , , , , , , , , , ,
	other tr	20a. Method of Dispos		ugneer	20h P	lace of Dispo			oau,	Vaki	Date P		on - City or T	Town State
0	00-	1 Burial 2 0		Removal from	1 0	emetery, crei	matory or o	other plac	ce)	1				
Baltimore,		4 Donetion 5	Othar (Special	y)	Deep	Cree	k Bap	tist	Cem.	18	/14/99	McHenr	у, Ма	ryland
<u>e</u>	Department Pa Department Important: any Injury	21. Signature of Fune	ral Service Lice	1500	٥				ss of Facilit					
0	89 E 8 8	1210	SUL. Y	12/10	Lasti				unera					
		23a. Part1. Enter the	disease, or com	plications that	caused the death	n. Do not ent	ter the mod	de of dvin	ond S	cardiac c	Oak Lan	d, Md.	21550	Approximate
5	Dhusiaian	shock, or heart for	ailure. List only	one cause on	each line.								i	Interval Between Onset and Death
	Physician /Medical	tmmediate Cause (Fin	al		1	6.3	1						1	
	Examiner	disease or condition resulting in deeth)	101	8.	No	m911	Va							
п					Due to (o	r as a consec	quenes of).	:					i	
	executed in and instransit	11.3%		b									i	
	and tran	Sequentially list condi	tions,	-	Due to (o	r as a consec	quence of):	:						
68760,	ian dian	Sequentially list condi- if any, leading to imme- causa. Enter Underlyi Cause (Disease or Inju-	ing										1	
376	certificate be executed ding physician and use as the bunal-transit	that initiated events resulting in death) Las		G	Due to (or	as a conseq	juence of):						1	
9	eath certifical attending place as the control of t	Trouding at doday, East												
0	andir use			d									1	
m	at the death of the attended for unestached for une	Pert II. Other significa	nt conditions o	ontributing to d	leath hut not resu	ulting in the u	nderbing (rausa niv	en in Part I		23h Did	I tohacco waa	contribute	to the causa of death?
0	ed by the detached	T GIT II. GUILLE GIGHT		Onthodiang to d	Outil Dot Not 1030	attang at the t	indenying t	oddao giv	ON WIT ON	•		M		obably 4 Unknown
0	that the ded b										1	Yas 2DIN	0 3071	obably 4 Olikilowii
ds	2 2 2										24a Was	s an autopsy	24b. V	Vere autopsy findings
Record	The law requir											ormed?	8	vailable prior to ompletion of cause
ec	has by 2 s ye 2 s													f death?
	The Ingention										00	Yes 2 N	0 6	Yes 2□ No
Vita	certificate rector, pag	25. Was casa referred examiner?	to medicat						26. Place	of Death	(Check only	опа)		
>	2 00	1 S Yes 2 No		Hospital: 1 🗆	Inpatient 2 🗆	ER/Outpatier	nt 3 De	OA Oth	er: 4 Nu	irsing Ho	ma 5 Ras	idence 6 🖎	Other (Spec	(fy) Scene
o	After thi funeral	27. Manner of Death		28a. Data	of Injury th, Day Year)	28b. Tima o	f :	28c. Injun Wor	y at		28d. Describe	how injury	burred	
0		1 Natural :	5 Pending invastigatio	> /.	/k_	Injury	М		Yes 200	No	Sunie	et L	5-100	& selt
Division	or Attendiate death. Director: A I in by the f	Suicide	6 Could not b	e 28e. Place	of Injury - At ho ing, etc. (Specif)	ma_farm, str	reet, factor	y, office	-		28f. Location	(Street and No	mber picRu	rel Route Number,
á	after after din b	4 Homicide		build	ing, etc. (Specif)	"Ce	100	ter	70	/	2 Ela	iwn, Stote)	tes	Oakland
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1[Certifuina Di	veicien. To the	best of my know		n occurred	at the tim	na data an	d niece	and due to the	Causa(s) and	manner	stated.
	To the Hospita within 24 hours To the Funeral completely filled		Medical Exar	niner: On the b	asis of examinat	tion and/or in	vestigation	in my o	pinion, dea	th occurr	ed at the time	, date and pla	ce, and dua	
	Med mple	29b. Signature and title	a of contiller	and man	ner stated.		20	c. Licens	a number		1	29d. Date sig	nned /Monti	Day Year
	P X P O	- / / I I I I I I I I I I I I I I I I I	A. Carrier	10	. 0		29	U. LIUOTIS	- Hallion			250. Date Si	prior (MOTILI	, way, 1001/
		1/1/4	cut	me	(ww)			0.	.C.M.I	Ξ.		Aug	ust 1	2, 1999
	12	30. Name and address	of person who	completed cap	se of death (Item	23a) (Type,	Print)							
	101	T. CAR	UN /IX	KO WA	Penn St	reet,	Balt	imor	e, Ma	ryla	nd 212	01		
	State	31. Dete filed (Month,	Day, Year)	32. F	Registrar's Signa			1	_					
	Registrar	Λ	HG 13	1999	herena	- Co	1	000	61					



State of Maryland / Department of Health and Mental Hygienes

Dhamis		1. Decedent's Name (First, Middle, La	st)		rtificate of	Douth	2. Dete of Deet	h No.	3. Time of Dee		
Physici /Medic		VERA C. GRA	,				Month AUGUST	Dey Y	ear		
Examin		4e. Fecility Name (If not institution, giv	e street and number)			4b. City, Town, or L		4c. County of			
		CUMBERLAND VI	LLA NURSIN	IG CENTE	ER	CUMBER	LAND	ALLE	GANY		
Funeral Director		5. Social Sacurity Number 6. S 213-50-1012	OM 2∏ F	975. last birthday)	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, AUG. 30	Year) ,1912 E	Birthpleca (State or For Country) PENNSYLVANI		
MOW III		10e. Stata 10b. County		c. City, Town or Lo	ocation				10d. Inside City Li		
23a or 28a-f show	ctor	MD ALLE	GANY	CUMBE	ERLAND				¶X Yes 2□		
or 28	Dire	10e. Street end Number			10f. Zip Code		10	g. Citizen of Whe	et Country?		
\$ 23	erai	235 PACA STRE			2150			U.S.A.			
al', or hems Examiner m	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eval Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:		was Decedent of P If Yes, specify Cuba 1 ☐ Yes 2 1 No	dispenic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yas or No- Rican, etc.)	Bleck, 1	Whita, atc.		
than "natural", The Medical Exc	Completed	15. Decedent's Ec (Specify only highast gre Elementery/Secondary (0-12)	lucation de complatad) College (1-4or 5+)	(Giva lifa. l		ork dona during most of working usa retired)					
art,		17. Fether's Neme (First, Middle, Last)		HC	MEMAKER	18. Mother's Nem	a (First Middle M	HOME	PENNSYLVANIA 10d. Inside City Limits Yes 2 No of Whet Country? A. Raca - American Indian, Bleck, Whita, atc. with: WHITE If Business/Industry ME Theme) Who is the Country The Country of the Country The Country of Town, State RLAND, MD D. 21502 Approximate Interval Between Conset and Deeth Contribute to the cause of death? The Country of Country The Countribute to the cause of death?		
D >	o Be	SAMUEL MARTI					A BARNE				
is marke aumatic	-	19e. Informent's Neme/Relationship (Type, Print)	19b. Mailir	ng Address (Street			mber, City or Town, Stete, Zip Code)			
n 27 is		JOSEPH GRAHAM		15207	TRAILRI	DGE RD.,					
ortant: if iter injury or off 8.		20e. Method of Disposition 1 → Buriel 2 □ Cramation 3 □ 4 □ Donetion 5 □ Other (Specify	Ramovei from State		sition (Neme of netory or other plea ORIAL PAR						
any in		21. Signeture of Funeral Service Licen	0 ,	11	Neme end Addra UPCHURCH	I ETIMEDAT	HOME, P	.A.			
edical miner transit miner tra	al Examiner	Immediate Causa (Final disasse or condition rasulting in death) Sequantially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due	to (or as a consequence to (or as a consequence)	juence of):	Diseas	e _		15 year		
tending or use a	lan/Medical	that Initiated events " resulting in death) Lest	d.	to (or as e consequ	uence of):						
d by the	by Physician/	Pert II. Other algnificant conditions of	entributing to death but no	t resulting In the ur	nderlying cause giv	en in Pert I.		1			
2 should	Completed b						24e. Wes an		available prior to completion of cause		
		05 Mar					1 ☐ Yes		1 ☐ Yes 2 ☐ No		
directo	o Be	25. Was case refarred to medical exeminer?	Hospitel:	0∏ED/0	Oth	er: Plece/of Deetl					
5 70	\vdash	27. Menner of Death 1 Neturel 5 Pending	1 ☐ Inpatiant 28e. Dete of Injury (Month, Dey Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injun	4⊌ Nursing Ho y et k?	me 5 ∐ Rasider 28d. Describe hov		specify)		
To the Funeral Director: Attar completely filled in by the funer	Certification:	2 Accident invastigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - building, atc. (St	At home, ferm, streedecity)		Yes 2□No	28f. Location (Str. City or Town,	aet end Number o Stete)	r Rural Route Number,		
To the Funeral D completely filled I	edicai	29e. Certifier (Check only one) 1 Certifying Phy	relcian: To the best of my iner: On the basis of examiner steted.	knowledge, deeth minetion end/or inv	occurred et the time astigation, in my op	ne, dete end plece, e pinion, deeth occurre	end due to the cau	use(s) end menne le end place, end	er es stated. dua to tha cause(s)		
# C (29b. Signeture end title of certifier	1) -		29c. License		29	d. Data signed (M	lonth, Dey, Year)		
			and the same of th								
28		30. Neme and eddress of person who c	7/2			766		AUGUST	11,1999		

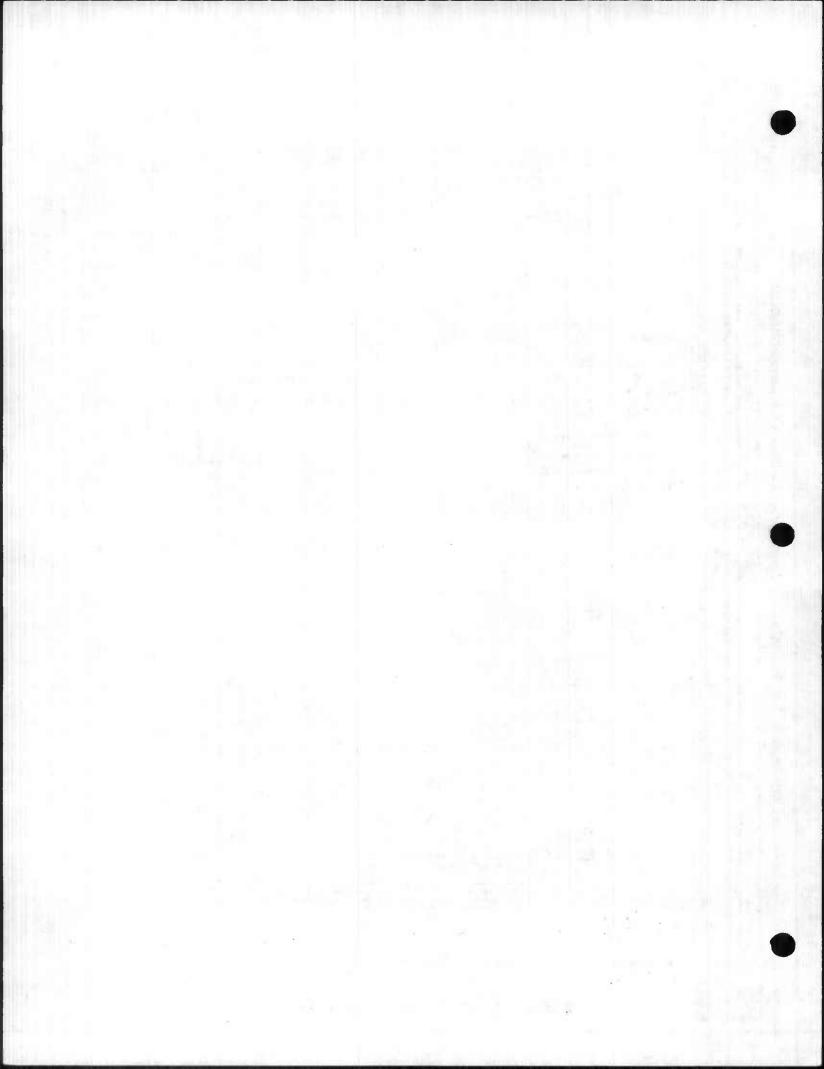
DHMH 16 Rav 6/95

Royally H. Yashorak

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vincent Guido August 11,1999 0410 a.m. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Months Days Hours Min. | Nov 1, 1921 9. Birthplace (State or Foreign Country)
Italy 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 77 Yrs. 216-18-1646 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 12 Smith Street 21502 USA Funeral 12. Was Decedent Ever in U,S.
Amed Forces?
12 Yes 2 No
If Yes, Give
Yeer or Detes: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Retired Tire Company permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: If them 27 is married other any injury or other to 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Angelina (LaNeve) Frank M. Guido 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Smith Street; Cumberland MD 21502 19e. Informent's Neme/Reletionship (Type, Print) Margaret Guido 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete 1 Duriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Patrick's Cemetery8/13/ Cumberland, MD 21. Signature of Funeral Se 22Scarper Fruneral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or compile tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) METASTATIC WNG ADENO CARCINOMA /Medical Examiner Examiner physician and s the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edical Due to (or es a consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 3 Probably 4 Unknown 1 Tes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Wes an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Daeth (Check only one) Hospitel: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Menney of Deeth 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Metural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29e. Certifier (Check only one) 29c. License number 050844 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHY SICIAN August //, 1999 ass of person who completed cause of death (Item 23a) (Type, Print) 30. Name und 912 SETON DRIVE CUMBERLAND, MD 21502 (DVERIA JOSE M.D. 126 32. Registrer's Signeture 31. Date filed (Month, Dey, Year) AUG 1 2 1999

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene 26700 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 4b. City, Town, or Location of Death 4c. County of Death HEG ART 1:08P JOSEPH /Medical 4s Facility Neme (If not institution, give street and number) Examiner ar If Under 24 Hrs. 8. Date of Birth (Month, Dilly, Yea JOHNS HOPKINS If Under 1 Year HOSPIT 8. Date of Birth (Month, Day, Year)
Aug. 22, 1989

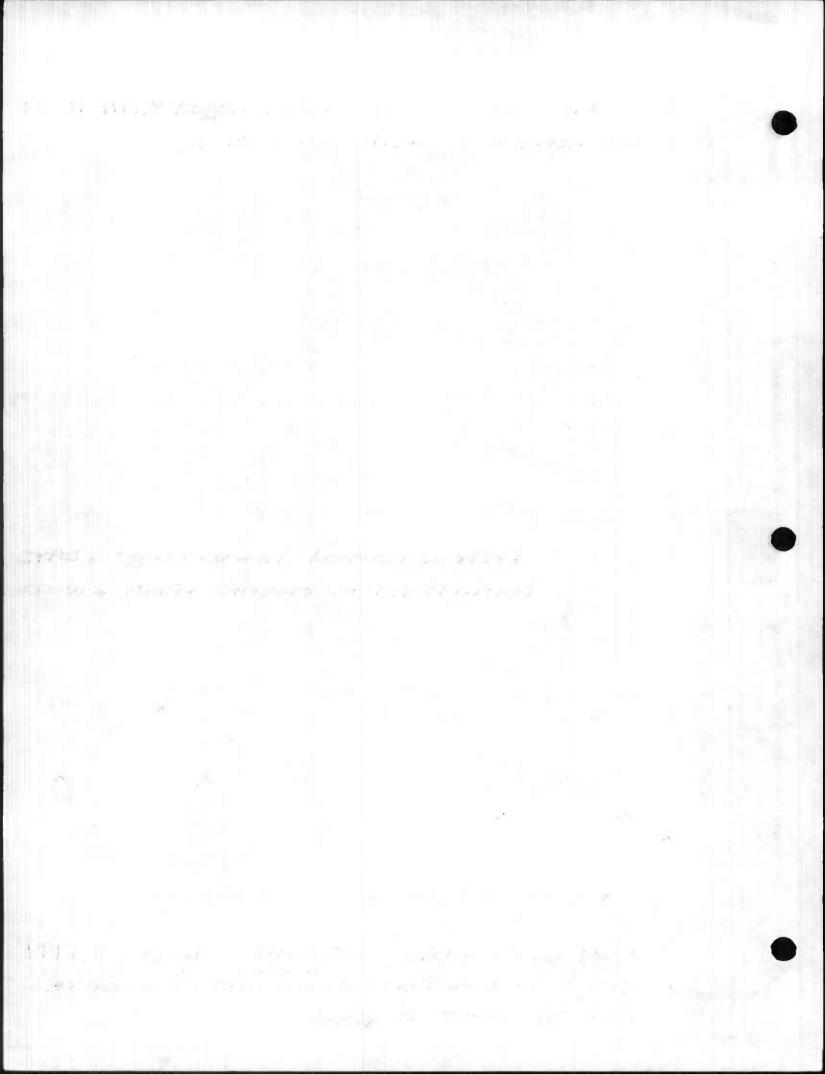
8. Birthplace (State Country)

Aug. 1989

Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 215-25-9930 1 XM 2 □ F 9 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show MD Carroll Eldersburg 1 ☐ Yes 2 No Director 288-1 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 886 Johnsville Road 21784 "natural", or itsms 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No 1 X Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complete Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Elementary Student permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important if Item 27 is mented other any Injury or other treatment. 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hegarty Lisa Ann Bausman 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (parents 886 Johnsville Road Eldersburg, MD 21784 Mr. & Mrs. Joseph Hegarty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place)
Crestlawn Mem. Gardens 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 8/12/99 Marriottsville, MD 21. Signeture of Funeral Service Licensee 23. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) Klasi CSykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications thet/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervet Between Onset end Death **Physician** /Medical Immediate Cause (Finel Intracrasial disease or condition resulting in death) Hemorrhage Examiner Due to (or es e consequence of): Examiner ORGAN TISYSTEM physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medicai Due to (or es a consequence of) USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. þ The law requires 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 KNo director. 25. Wes cese reterred to medical examiner? 80 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2NNo 1 Inpatient 2 ER/Outpatient 3 DOA sita 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? Certification: Atter or Attanding 1 Netural 5 Pending n 24 hours after death.

• Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P23912 Avoust 8, 199 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFEST BALTIMORE, HD 21287 DYNNE ORRISON JOHNS HOPKING HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 1 1 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hughes, James Elwood 1334 luguet 10 19 4a. Fecility Name (If not institution, give street end number) 4c. County of Death WICOMICO 4b. City, Town, or Location of Deet PENINSULA REGIONAL MEDICAL CENTER SALISBURY 6. Sex/ 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 28 1934 9. Birthplace (State or Foreign Months Deys Hours Mary Land 214-30-8625 65 Yrs. Apr Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Dorchester Toddville 1 ☐ Yes 275 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2531 Toddville Rd. 21672 U.S.A. 11. Meritai Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 25 Married 1□ Yes ZINO Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decadent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) wire belt mfg. machine operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Elwood Hughes Zenia Phillips | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sue Hughes - wife 2531 Toddville Rd. Toddville MD 21672 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlai 2 ☐ Cremetion 3 ☐ Removal from Stete Dorchester memorial Park 8-13-99 4 □ Donation 5 □ Other (Specify) Cambridge Maryland 21. Signeture of Funeral Service Licansee 22. Name end Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Bet Onset and Death immediate Cause (Final Cardiogenic stock. disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Athewederons. nonary Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ellimidum 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner sician and burial-transit The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

show

238-1

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Berrs 23s

natural, or

Hygiene.

marked

Department of Health and Important: If Item 27 is m any injury or other traum 90cs.

Pages 1 and 2 should be nent of Health and Mental

the Medical Examiner

altimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Director

Funeral

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Completed

Be

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MD

/Medical

Certification: To

by Be

Physician/Medical Examiner Completed

Medical

State

Registrar

29a, Certifier

the Š been signed to should be det page 2 this certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

25. Was case referred to medical 1 ☐ Yes 2 ☐ No 27. Manner of Deeth

Naturai 5 Pending investigation 2 Accident 3 Sulcide 4 Homicide

6 ☐ Could not be determined

28a. Date of injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

 Location (Street end Number or Rural Route Number, City or Town, State) 🎜 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. Descripting Physicism: 10 the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

28d. Describe how injury occurred

29c. License number 25036 29d. Dete signed (Month, Day, Year) 110199

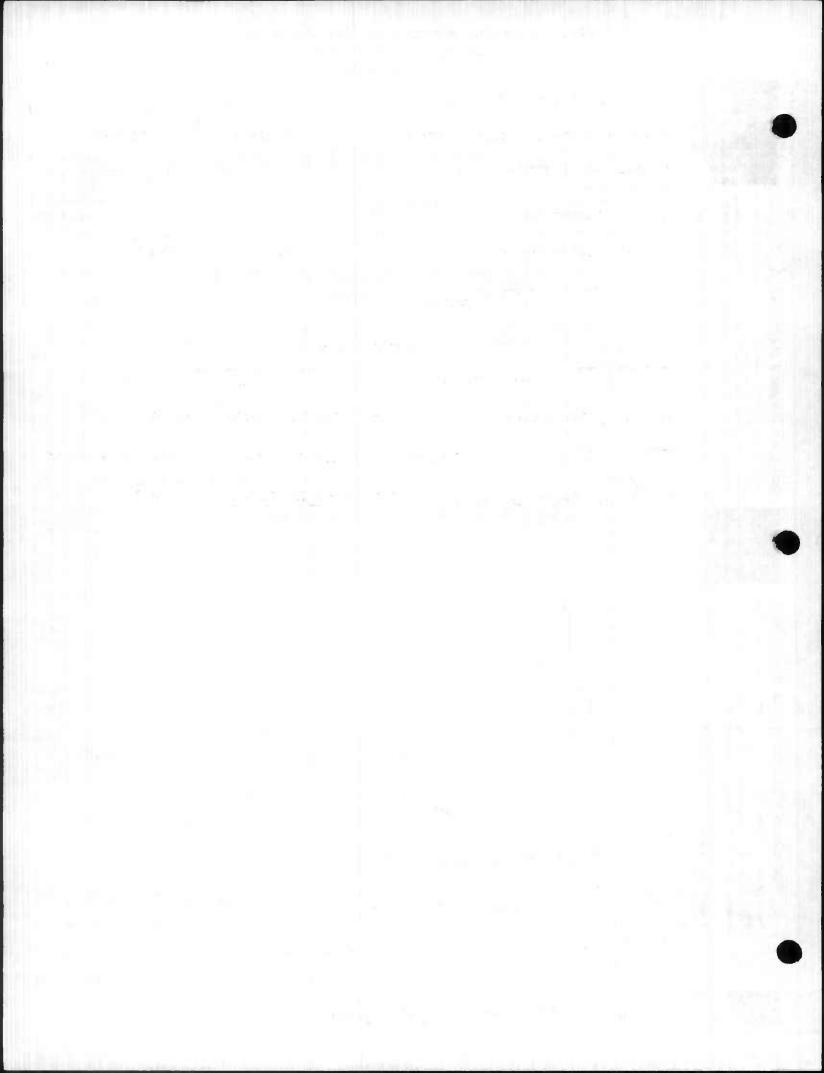
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENETERN Share Drive SALISBURY. M.D 614

31. Date filed (Month, Day, Year) AUG 1 2 1999

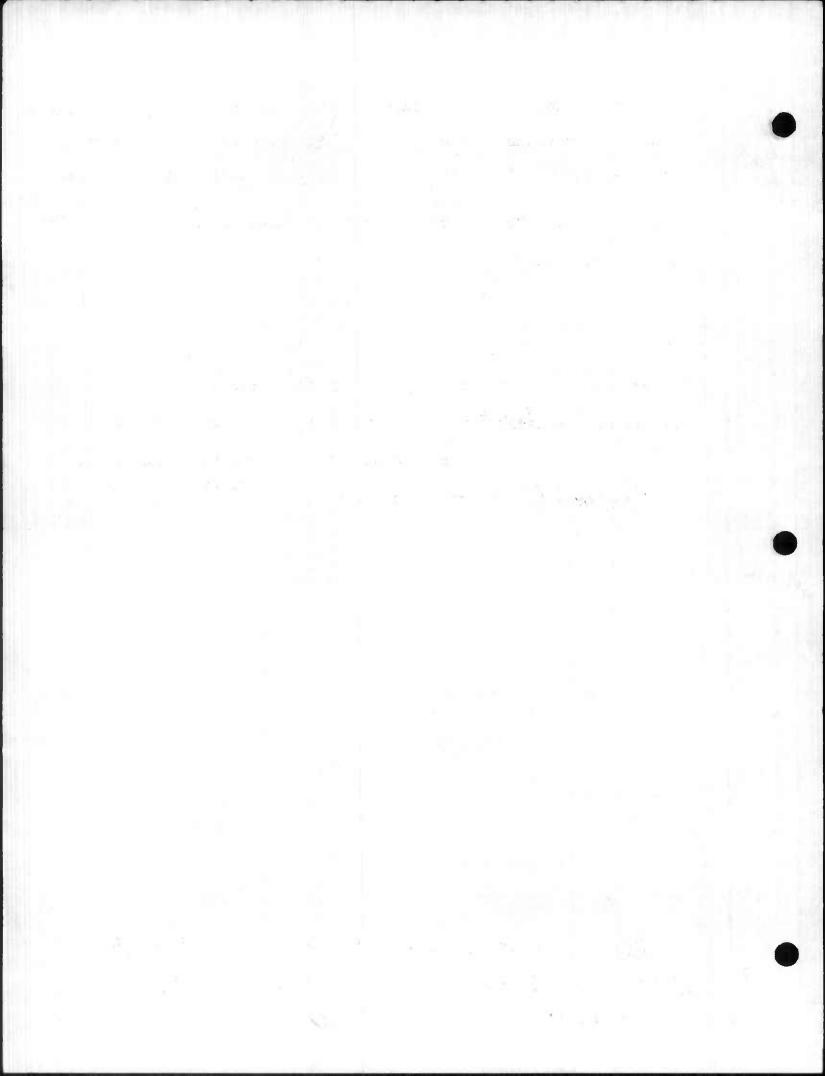
29b. Signeture and title of pad fier

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 9 9 26702

				(Certifica	ite of	Death	F	Reg. No.	20	106.
Physicia	20	1. Decedent's Neme (First, Middle, Last)						2. Dete of Dea Month	th Day	Year 3.	Time of Death
Physicia /Medic		Mary Cor	nelia	Jac	kson			Aug.	1, 199		1:00 PM
Examin		4e. Fecility Neme (If not institution, give s	treet and number)				4b. City, Town, or	Location of Deeth		1,000	
		Blue Point Re	hab. Cent	cer			Balto.				
Funeral Director		5. Sociel Security Number 6. Sex 215-28-8151	14 0575	yrs. last birth	Month.	er 1 Yeer a Days	Hours Min	6. Date of Birtl (Month, De) 8/16/1	, Year) . 8 9 9	9. Birthplace Country) Mary	(State or Foreign land
Hygiene. ther than "natural", or items 23s or 28s-f show ent, the Modical Examinat must be notified at		10a. State 10b. County	100	c. City, Town	or Location			211	11	10d. I	naide City Limits
유급	Po	MD. Balto.	CO	231/1	Corbei	-+ D	d Mon	kton, M			☐ Yes 2 No
284	Director	10e. Street end Number	20.	LUIT		ip Code	.u. Hon		IOg. Citizen of \		41
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ral', or items 23a or 28a-f show Examiner must be notified at	by Funeral	1 Never Married 2 Merried 3 Vidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		If Yes, sp 1 ☐ Yes		Hispenic Origin? (5 pen, Mexican, Puer Specify:	to Rican, etc.)	Specify Specify	ok, White, etc.	
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lic e	ToB	Garfield	Walton	ı			Anna R	oberta	Davis		
E		19e. Informent's Name/Reletionship (Typ.	oe, Print)	19b.	Meiling Addre	ss (Stree	t end Number or A	ural Route Numbe	r, City or Town,	State, Zip Cod	le)
27 le r tra	1	Gladys M. Robin	daughter	1			rt Rd.			2111	_
r other tr		20a. Method of Disposition	2	0b. Plece of I	Disposition (N cremetory or	ame of	1	Date	20c. Location -	City or Town,	State
tant: If		Burial 2 Cremation 3 Re	Tom State		Chape	el C	em.	8/5/99	Monkto	on, MD	
Important: If any injury o		21. Signeture of Junerei Service Licentee	V. Kente	_			ess of Facility J neral H	arretts			21084
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has been sign ge 2 should be	Completed by							24e. Wes a perfor		evailebl	utopsy findings le prior to tion of cause 1?
page	5							1 🗆 Y	ea 2 No	1 ☐ Yes	s 2 No
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er th		27. Megner of Death	28a. Date of Injury (Month, Day Yea	28b. Tir		28c. Inju		28d. Describe h			
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Il Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S)	At home, fem	n, street, fecto	ry, office		28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural Rou	rte Number,
winin za nours androgam. To the Funeral Director: After completely filled in by the funer	edical	29e. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	clan: To the beat of my er: On the basis of exa- and menner stated.	knowledge, minetion end/	death occurre or investigation	d at the ti	ime, dete end pleco opinion, deeth occ	e, end due to the curred at the time, o	euse(a) and ma late and piaca,	inner as stated and due to the	cause(s)
To the	×	29b. Signeture and title of certifier			2	9c. Licen	se number	1	9d. Dete signe	d (Month, Day,	Year)
		> delborah	Moris	M		29	1364		8/5/	99	
3		30. Neme and address of person who con	Dr. #250	(Item 23a) (T	ype, Print)	Mi	115. M	D 2	1117		
Stat	е	31. Dete filed (Month, Day, Year)	32. Registrar'a S	igneture	3						

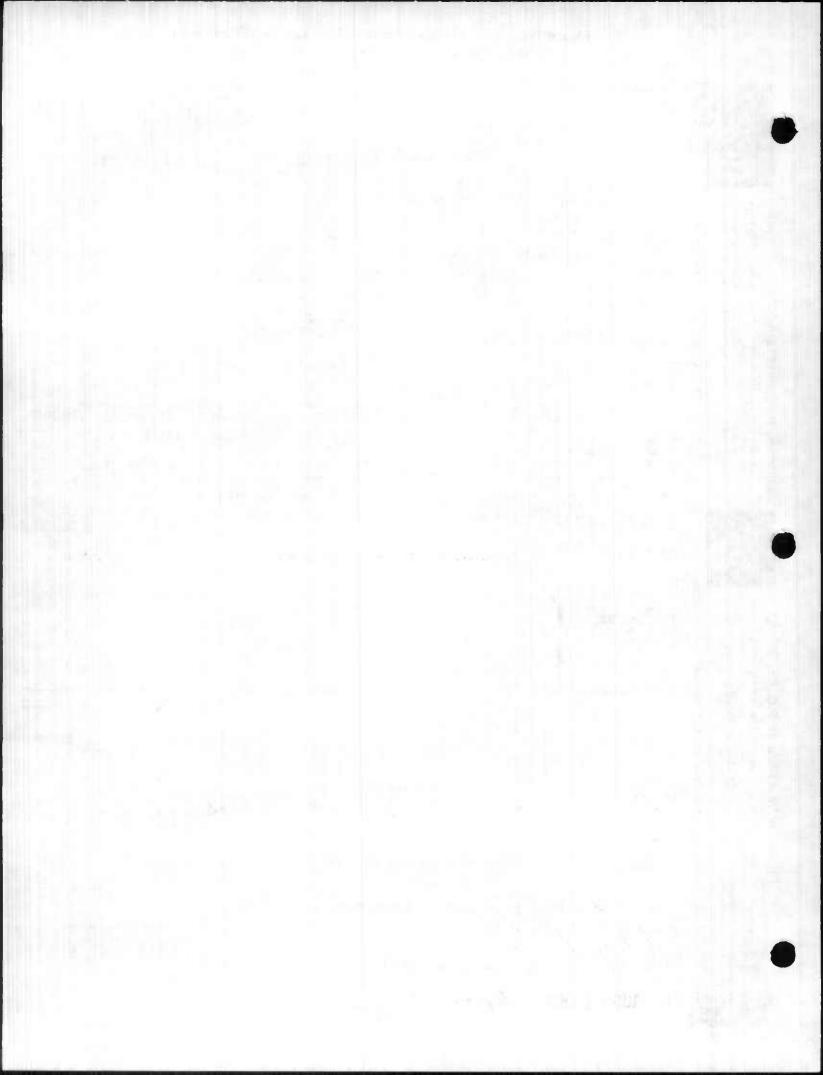


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death

				Cei	uncan	7 01	Deam		F	Reg. No.		
Physician /Medical	Decedent's Name (First, Middla, Edna	F.		Judy						3, Day 199	9 ^{Yaar}	3. Time of Death 10:57pm
Examiner	4a Facility Name (If not institution, 13507 Winter							wn, or Lo	ocation of Daath	4c. County		egany
Funeral Director	5. Social Security Number 216-22-6894	Sax 1□M 2F	7. Age (In yrs.		If Under Months	t Year Days		24 Hrs. Min.	8. Date of Birt (Month, Day Feb 4	Year)909	9. Birthr	place (State or Foreig
pue *	Usual Residence of Decedent 10a. State 10b. County										1	Od. Insida City Limits
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3a or 2	10e. Street and Number 13507 Winter	Lane			10f. Zip	Code	215	502		10g. Citizen ot \ USA	what Cour	ntry?
P 5 5 5	11. Marital Status 1 Nevar Marriad 2 Married X Widowed 4 Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces2- 2 ⊡No e	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 □ Yes 2 □ No Specify:						Blee	e - Americ ck, White,	
I 21215-002(ed within 72 hours e yojene. er than "neturel", o it, fre Wolfcel Exec. Completed by	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education		16a. Deced (Give life. L	kind of wor OO NOT us	k done e retire	pation during most ed)	of work		16b. Kind of B	usiness/in	
Maryland 21215-0020 d 2 should be filed within 72 hours of th end Mental hygiene. 7 Is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	17. Father's Name (First, Middle, La Wrussell Wint						18. Mothe		e (First, Middle,		ne)	
Mary d 2 sho lith end l 27 is me traum	19e. Informant's Name/Relationship Donald E. Laf	ferty		19b. Mailin 2409	g Address Cypi	(Stree	s Lak	eror Aur	al Route Numbered; Hope	er, City or Town, Mill:	State, Zip	C 28348
Baltimore, semit. Peges 1 ar separtment of Hea mportant: If Item; iny Injury or other ands.	20a. Method ot Disposition 1 ABuriai 2 Cremetion 3 4 Donation 5 Other (Spe		State	Place of Dispo	natory or of	her pla		ia ric	Date 18/11/	20c. Location		
Baltii permit. I Depertm Importar any Inju	21. Signature of Funeral Service Lk		1,000	22	Scarr	381	erspt Farilit	iner	cal Hor	ne P.A 2150		
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OX 68760, certificate be executed nding physician end use as the buriel-fransit n/Medical Examiner	Cause, Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	c	Due to (o	to (or es a consequence of):								
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VITAL REC sician: The law certificate hes to director, page 2 s									10	res 2 No		Geetn? ☐ Yes 2☐ No
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DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	1 Naturel 5 Pending Investiga 3 Sulcide 6 Could no determin	tion t be 28e. Plece	M 1 Yes 2 No						28f. Location (S	Streat and Numi	ber or Rur	al Routa Number,
DIVISIGE To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying (Check only one) 2 Medicat Ex	Physician: To the laminer: On the ba	sis of examina	wledge, deeth	occurred ovestigetion,	et the t	time, date en opinion, dee	d plece,	end due to the red at the time,	ceuse(s) and m date and place,	enner as s	steted. to the cause(s)
within To the comple	29b. Signature and title of certifler	/ And thenth	or stateu.	_	290	. Licar	nsa number			29d. Date signs	ad (Month,	Day, Year)
5	1 xacul	har	,			D0	9157			Aug	8,	1999
mes	Paul Snow M.					Cu	mberl	land	MD 21	1502		
State	31. Date tile A Han, Pag Y499	9 50	Signa	ature	dra	~	,					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month John Scott Keiling AUGUST 9 1999 6:40 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Hosptial **Allegany** Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Deys 1 M 2 F Months Hours Yrs 577-07-4878 08-Mar-07 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11110 Welsh Hill Road 21532-12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice-President Insurance company 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John S. Keilling, Sr. Isabella Dudley 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11110 Welsh Hill Road Mary Keiling Frostburg Maryland 21532-20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removel from Stete Frostburg Memorial Park 12-Aug-99 4 ☐ Donation 5 ☐ Other (Specify) Frostburg, Maryland 21. Signature of Funeral Service Licepade 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest hock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Nephro Sclero Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Berten & Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Pamor eatitis 1 Yes 2 No 24b. Were autopsy findings available prior to completion of ceuse of death? Congestite beent Foilure. 24a. Was an autopsy performed? Obstructive 1 Yes 2 No 1 ☐ Yes 2 ☐ No

ician and buriel-transit The law requires that the death certificate be executed Box 68760 USB P.O. signed by the a Records, Division of Vital Attending Physician: this

death.

To the F within 2

ò Hospital

Physician /Medical

Examiner

Examiner Physician/Medical Be Completed by

Certification: To Affer n 24 hours efter death.

Ne Funeral Director: A pletely filled in by the fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

the Medical Examiner must be notified at

"natural", or Items 23s or

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Completed

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death

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural"—nany injury or other traumatic event

S my 2

Registrar

completely

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manper of Death 1 Netural 5 Pending investigation 2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29e. Certifier

Medical

6 Could not be determined

Hospitel: 1 Inpatient 28a. Dete of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 281. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Place of Deeth (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

14464 Terrace Frostburg

AUGUST

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 48 M.n. ander

32 Registrar's Signature

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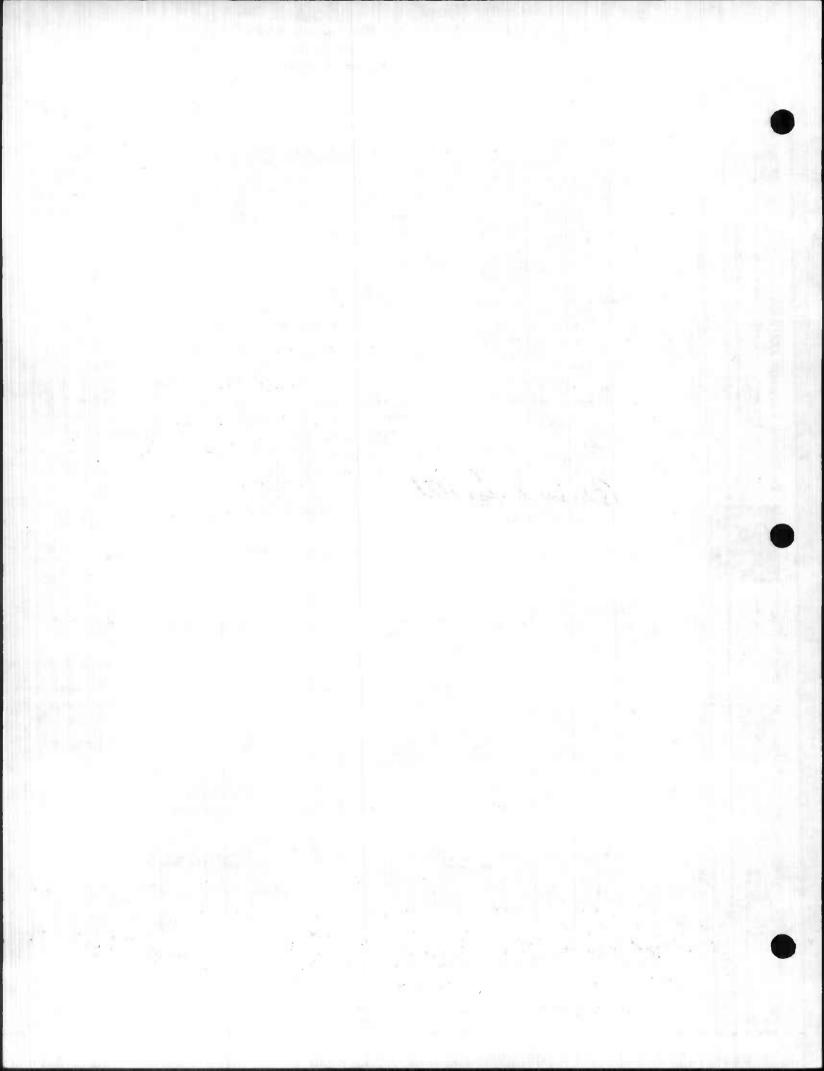
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State of Maryland / Department of Health and Mental Hygien

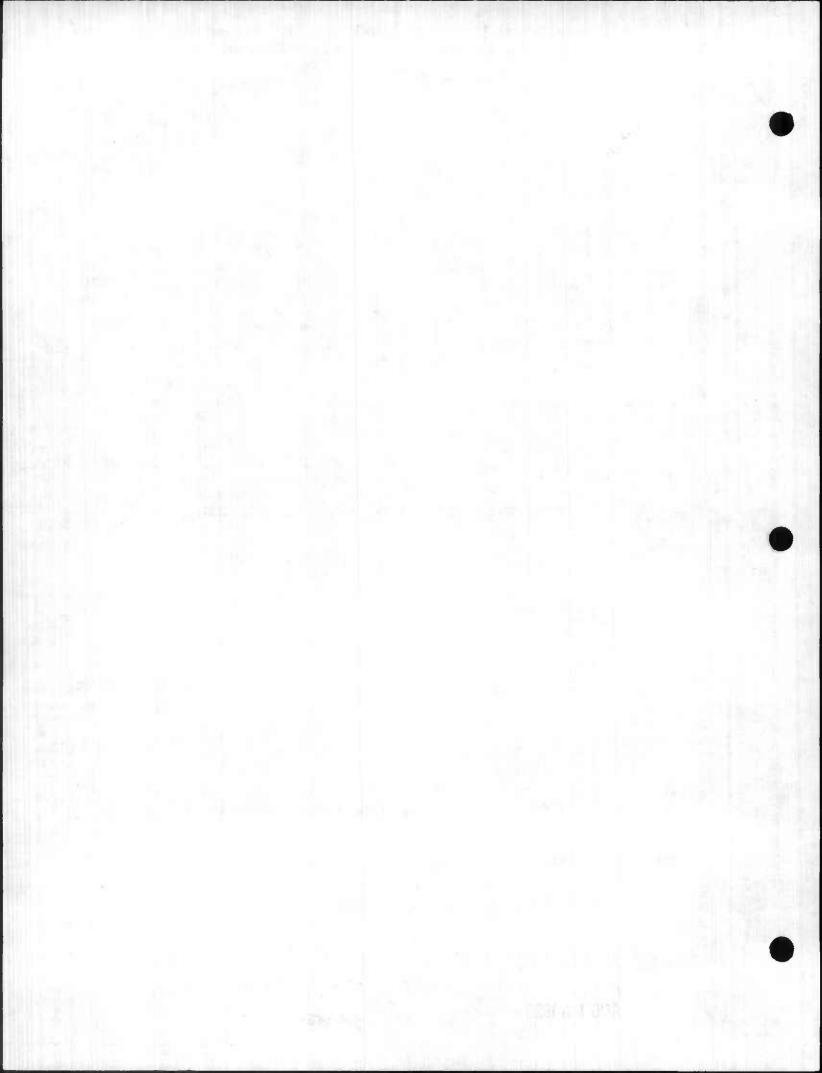
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician ROSE LEE KLOTER AUGUST 10 1999 6:45 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 23,1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 N F Yrs. 80 215-42-4845 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 No Yes 2 No Director WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nema 23e or 12 North Main Street, Apt. 402 26726 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: by White 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiene important: If fam 27 is marked other that any ijury or other traumatic avant, trauping. Nursing Assistant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer E. Beavers Florence L. Paugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Kokta/Daughter 7750 Rossville Blvd. Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Aug. 12 4 ☐ Donation 5 ☐ Other (Specify) Bloomington Cemetery Bloomington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** · Corelio-nasailar accident 48 hrs. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner 12 hrs luck The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of 2 Years Box 68760 tension Physician/Medical app p Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ۵ 4 mutension bengis d be del Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? s need should 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No I or Attending Physician: after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 tnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Es Makammen war, no D 28932 AUGUST 12 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Shafiei, M.D. Seton CUMBERLAND, 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 1 6 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Kerr			Certificate of	Death	Reg. No. 99	26/06
Ohyginlar	Decedent's Name (First, Middle, Last)			2. Date of Month	Death Day Year	3. Time of Death
Physiciar /Medica	victoria sus	an Ke	err	Augus	t 13 199	9 03:32 AM.
Examine	4a Facility Name (If not institution, give street an			4b. City, Town, or Location of De	ath 4c. County of Dea	th
M		Arch Street	thday) If Under 1 Year	Cumberland If Under 24 Hrs. R Date of	Allega	
Funeral Director	5. Social Security Number 214-02-1342 6. Sex Usual Residence of Decedent	7. Age (In yrs. last bin	Yrs. Months Days	Hours Min. 8. Date of Month,	27, 1964	thplace (State or Foreign ountry) MD
1 1	10a. State 10b. County	10c. City, Town	n or Location			10d. Inside City Limits
the Maryland 28a-f show notified at	MD Allegan	У	Cumberlar	nd		1 TYes 2 No
6 98 5	10e. Street and Number 128 Arch Street		10f. Zip Code	21502	10g. Citizen of What C	ountry?
S E E	3 ☐ Widowed 4 ☐ Divorced Yaar	Decedent Ever in U,S. ed Forces? Yes 2	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yas or an, Maxican, Puerto Rican, etc.) Specify:	No- 14. Race - Am Black, Whi Specify: Wh	te, etc.
D-0	15. Decedent's Education (Specify only highest grade comple	nted)	Decedent's Usual Occur (Give kind of work done	pation during most of working	16b. Kind of Business	Andustry
led within 72 ho hydere. her than "natura it, the Medical J	Elementary/Secondary (0-12) Colle	ige (1-4or 5+)	(Give kind of work done life. DO NOT use retire	are giver	New Life	Shelter
	17. Father's Name (First, Middle, Last)	Ce	erciried c	18. Mother's Neme (First, Midd		Sherrer
Hand of the second of the seco	Clonn D Korr			Dorothy L	(Dawson)	
Alary 2 shou and M is man summer	19a. Informant's Name/Reletionship (Type, Print Dorothy L. Kerr) 19b 5 1	. Meiling Address (Street 4 Rose Hi	and Number or Rural Route Nur 11 Avenue; Cu	nber, City or Town, State,	Zip Code) MD 21502
re, n Heam 27 other tr	20a. Method of Disposition		Disposition (Name of	Date	20c. Location - City or	Town, State
altimore, mit. Pages 1 a partment of Hea portant if Item; y Injury or other 68.	1 Daurial 2 Cramation 3 Removal 4 Donation 5 Other (Specify)	rom State	y, crematory or other pla	orial Par8/17	Cumborle	and MD
Danie Porte	21. Signature of Funeral Servica Licanus	HILL		Alfaraneral H		ma, MD
n seria	Michael (Star	the	_	and, Marylan		
	23a. Part1. Enter the disaasa, or complications to shock, or heert failure. List only one ceuse	hat caused the death. Do r	not enter the mode of dyi	ng, such as cardiac or respirator	arrest,	Approximate Interval Between
Physician /Medical Examiner	Toodking in douling		guns /	not wound		Onset and Death
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T.O. DOX out the death cert d by the attendire letached for use.	d					1
the de de	Part II. Other algnificant conditions contributing	to death but not resulting in	the underlying cause gi	ven in Part I. 23b. D	ld tobacco use contribut	e to the cause of death?
ad by the detache				1	□ Yaa 20(No 3□F	robably 4 Unknown
The law requires that the decate has been signed by the a page 2 should be detached.				24a. W		Were autopsy findings
o b o o o					entormed?	available prior to completion of cause of death?
ysician: The law his certificate has be I director, page 2 s					XYas 2□No	1 ☐ Yes 2 ☐ No
entificat sctor, p	25. Was case referred to medical			26. Place of Death (Check on		
Physician: this certific ral director.	1 X Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Ot	her: 4 Nursing Home 5 R		ecify)
ttending Pi death. ctor: After tr y the funera		the how injury occurred Shot (Street and Number or Frown, State) 2 8				
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b Madical Certii		the best of my knowledge	death occurred at the tid/or investigation, in my	me, date and place, and due to to ppinion, death occurred at the time	ne cause(s) and manner a	s stated. e to the cause(s)
To the comple		1	29c. Licens	se number	29d. Date signed (Mon	th, Day, Year)
	AtoM A 1	Jadis	MP O.	C.M.E.	August 1	3, 1999
w	30. Name and address of person who completed	cause of death (Item 20a) (1-11	V ** 1 * 4 *	August I,	1, 1, 2, 2, 2
7		dent2, 111 P	enn Street,	Baltimore, Mar	yland 21201	
State Registrar	31. Date filed (Month, Day, Year) AUG 1 6 1999	32. Registrar's Signature	S. Som			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 80 **Physician** 10:00 p.m. Helen Katherine Kalbaugh /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 25 F Months 84 Yrs 217-05-0389 11, Feb. 1915 Director Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show must be notified at Md Allegany Westernport 1 ☐ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 25701 Shady Lane, SW 21562 United States Norms 23a Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2√ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. other than Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Home Department of Health and Mantal Hy Important: If Ihm 27 is marked other any Injury or other traumatic 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Willis B. McCombs Moran Fmma 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Scott / Niece Box 6 N Huttonville, Ill 62433 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete DeBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 8/5/99 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery Westernport, Md 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility 111 Church St. w Boal Funeral Home Westernport, MD 21562 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Dy Syly Minis 30 mintes Examiner Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 980 detached Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Sept. 53 P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 SUnknown signed b Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 cerebrovisali 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate G MANNE Ale To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturet 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier August 3 D21244 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

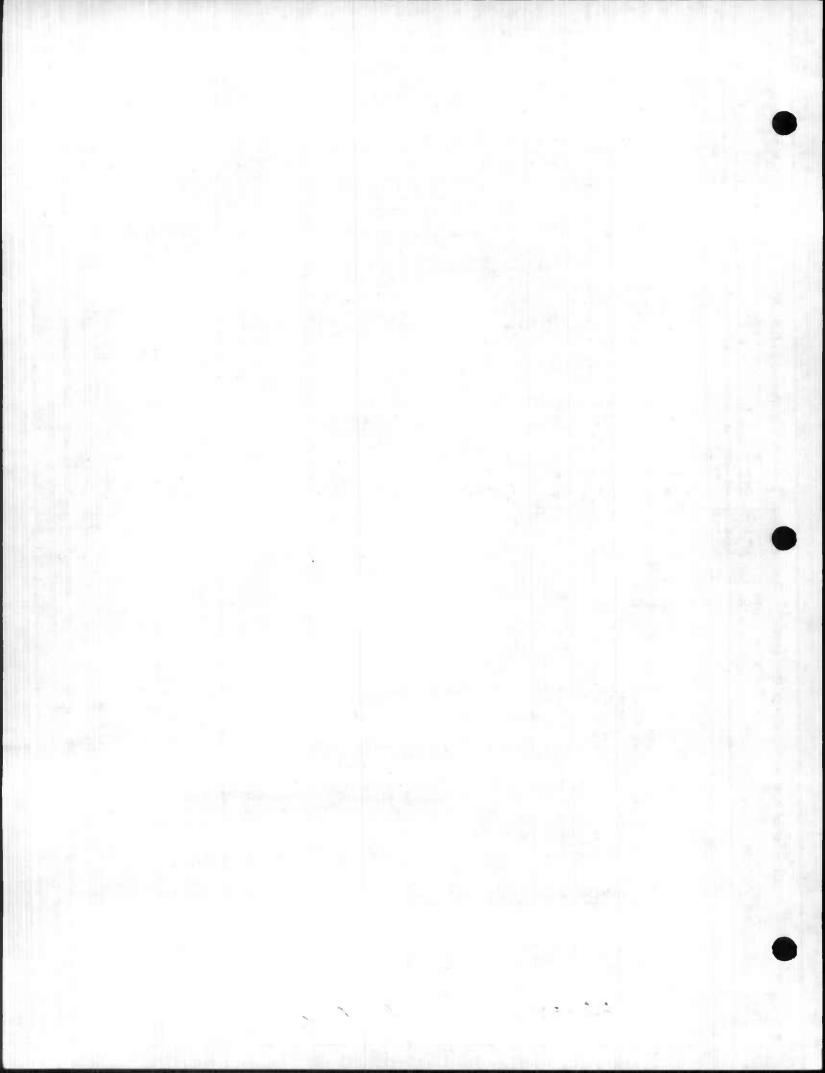
State

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32. Registrar's Signeture

AUG -

5 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month THEODORE KAY, MILTON JR. 1999 6:10pm August 10 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Civista Medical Center LaPlata Charles If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (in yrs. last birthday) 9. Birthplace (State or Foreign Months Days Yrs. 46 VIRGINIA 579-68-9531 DEC. 29, 1952 Usual Residence of Decedent 10d. Inside City Limits 10e State 10h County 10c. City. Town or Location 1 Yes 2\0\0 MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 GARNER AVENUE UNITED STATES 20602 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 M Yes 2 D No 197 If Yes, Give Year or Dates: 197 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1971 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 1972 WHITE 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 OWNER/OPERATOR ROOFING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THEODORE MILTON KAY, SR. MARILYN TURNER 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. JOSEPHINE KAY - WIFE 315 GARNER AVENUE, WALDORF, MD 20602 20a. Method of Disposition 1XXBurial / 2 □ Cremetion 3 □ Removel from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 Other (Specify) TRINITY MEM. GARDENS, AUGUST 14, 1999, WALDORF, MD MGB Funeral Service Licensee THE HUNTT FUNERAL HOME, INC. MARK BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to 24e. Wes en autopsy

Physician /Medical Examiner

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24 hours 6 Hospital

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Physician/Medical

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Division of Vital Records, P.O. Box 68760,

Pages

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a	. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end fitle of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D - 46246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

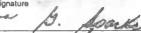
Southern Maryland Oncology

Ashraf M. Meelu/MD 10 St.Patrick Drive, Suite 105, Waldorf, Maryland 20603

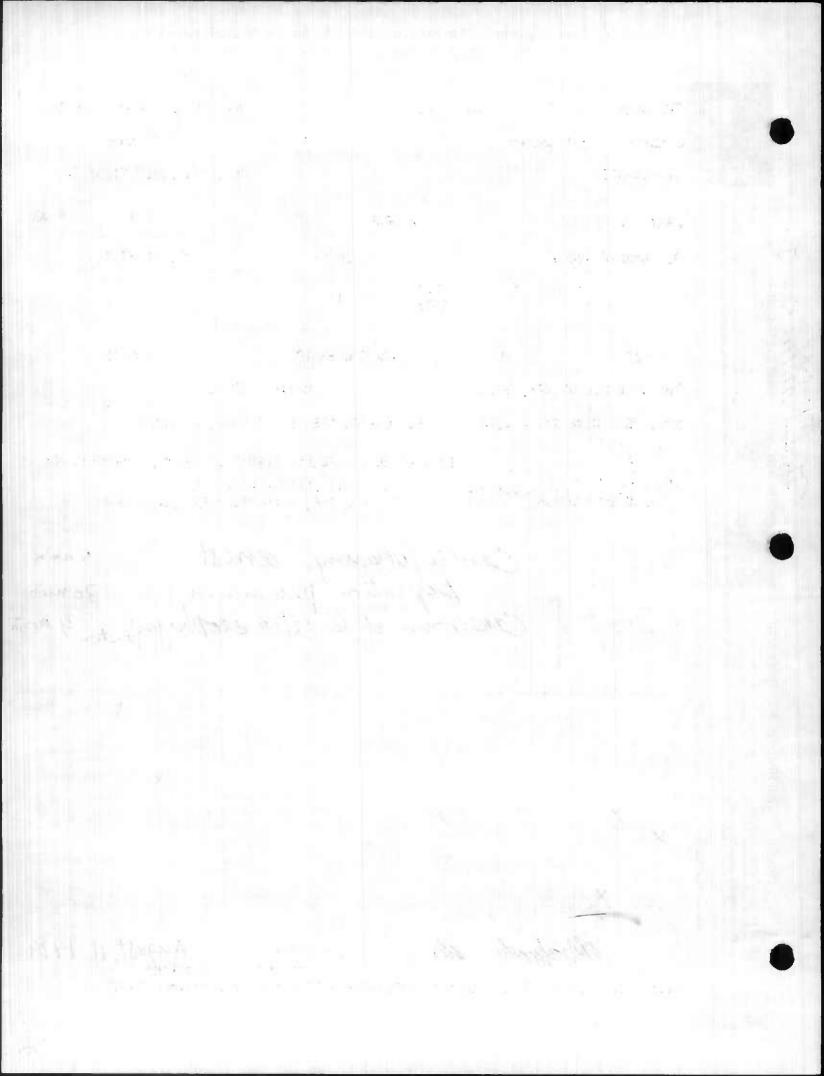
32. Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

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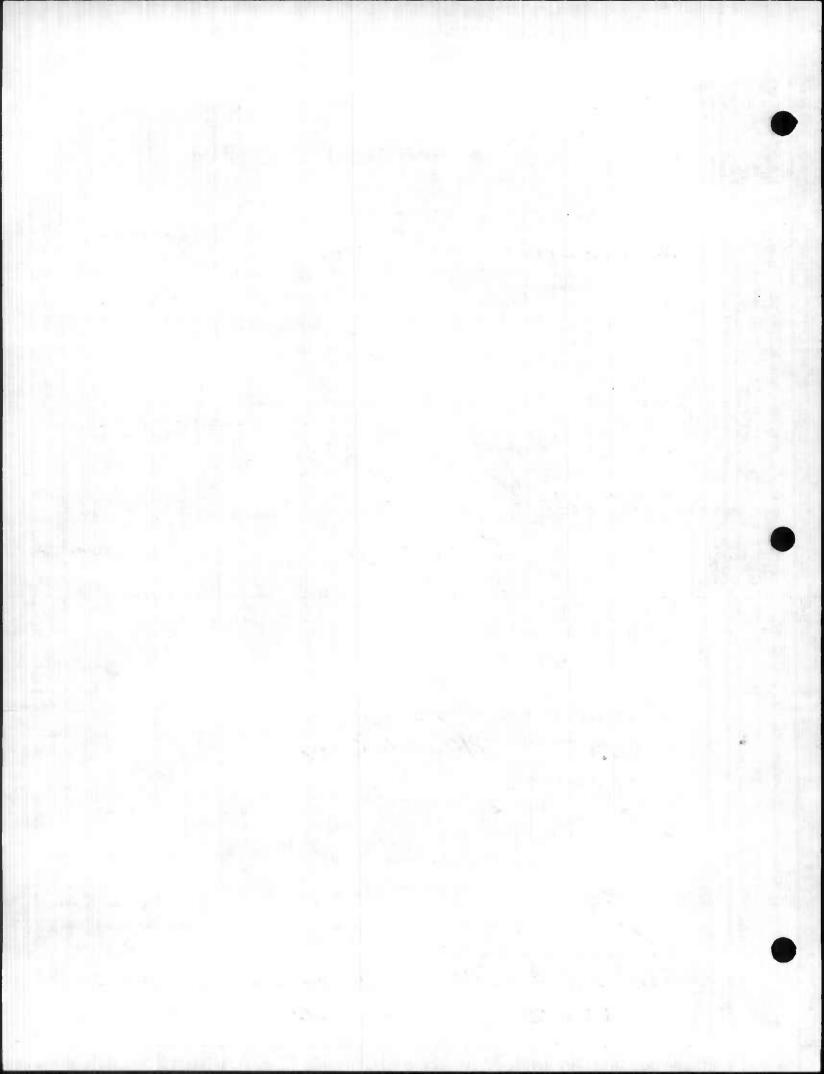


DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9

	1. Decedent's Name (First, Middle, Last)	or Death	2. Date of Death	g. No.	3. Time of Death
Physicia	Althea Catherine Lashbaugh		Month	Dey Yes	ar
/Medica Examine	4-5-10-10-10-10-10-10-10-10-10-10-10-10-10-	4b. City, Town, or	Location of Death	6, 1999 4c. County of D	9:40 am
Examine	Sacred Heart Hospital	Cumberla	and	Alleg	any
Funeral Director	216-09-8507 12 M 2M 7 95 Yrs.	1 Yeer If Under 24 Hrs Days Hours Min.			Birthplace (State or Foreign Country) [aryland
with the Maryland a or 28a-f show Libe notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md Allegany Barton				10d. Inside City Limits 1 Yes 2 No
uit with the Marylar 23e or 28e-f show unt be notified at	MO Allegany Barton 10e. Street and Number 10f. Zipe 18725 Temperance Row 2	Code 1521		og. Citizen of What	
Nerra Nerra	1 Never Married 2 Married 1 Yes 200 No H Yes, Give 1 Yes 200 Year or Dates:	ent of Hispanic Origin? (S fy Cuban, Mexicen, Puer D.No Specify:		14. Race - A Bleck, W	merican Indian,
Maryland 21215-0020 of 2 should be fluid within 72 hours at th and Mental Hygiene. 7 is marked other than "natural", or trainredic event, the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown 16a. Decedent's Usual (Give kind of word life. Do NOT use Homemake) Homemake	done during most of wo e retired)	rking	6b. Kind of Bustne	ss/industry
Billing High			me (First, Middle, N		
Abrital head of the every	John Robertson	Helen	a Lyons		
and Manual		(Street and Number or R	ural Route Number,	City or Town, State	e, Zip Code)
C 12 24 h	Judy Donaldson 46 Douglas	s Avenue,	Lonaconir	ng, MD 2	1539
Baltimore, semit. Pages 1 a bepartment of Hes moortants if then my injury or othe side.	20a. Method of Disposition **MXBunial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nem cametery, cremetory or of Laurel Hill Cells)	her plece)		Oscow Mi.	
Ball permit, Depart Import any inj any inj		Address of Facility		Church St	
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition				Approximete Interval Between Onset and Death
Examiner	resulting in death) Due to (or as a consequence of):	0/18			byers
os the burner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of):				
the death cert by the attendin ached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying ce	use given in Part I.	23b. Did tol	bacco uss contrib	uts to the causs of death?
			1 □ Ye	2 2 3 3 5 3 5 3 5	Probably 4 Unknown
necords, relative that he law requires that hes been signed by the control of the	Hypertension Atheoselectic Co afor disease.	Vonary	24e. Wes ar perform		b. Were autopsy findings available prior to completion of cause of death?
F # 4 6	afor discase.		1 □ Ye	s at No	1 ☐ Yes 2 ☐ No
ysician: The	25. Was case referred to medicel axaminer?		ath (Check only one	9)	
- 5 00		A Other: 4 Nursing } Ic. Injury at Work? 1 Yes 2 No	lome 5 ☐ Reside 28d. Describe ho		Specify)
To the Hospital or Attending Physical Carlo and To the Funeral Director: After this completely filled in by the funeral director.	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, building, etc. (Specify)		28f, Location (Str City or Town	reet and Number or , Stete)	r Rural Route Number,
To the Hospital within 24 hours a To the Funeral D completely filled i					
Mithin To the comple		License number	25	d. Date signed (M	onth, Day, Year)
- 3 - 0	Vlnanck lane 1	21488		AUGUST 6	, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I homas J. Devin MD, 20 Dougla.	Ave, Los			
State Registrai	31. Date filed (Month, Dey, Year) 32. Registrar's Signature	branch			



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 10 Am August 20 1999 JAMES RICHARD MYERS,
4a Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location & Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carrol1 H Under 1 Year H Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. Jan 22, 1914 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 85 Director 213-38-8483 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1□ Yes 2□ No Directo Maryland Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 United States "natural", or Items 23s 101 Willis Street 21157 12. Was Decedent Ever in U,S. Armed Forces? 1 | Yes 2 | No II Yes, Give¹ Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 25 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental High Important: If Item 27 is marked other any Injury or other re-**Healthcare** Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Abigail Nourse John Edgar Myers, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101 Willis Street, Westminster, MD Dorothy R. Myers/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State > Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 8/9/99 Westminster, MD Westminster Cemetery 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Myers Funeral Home 91 Willis Street 21157 Westminster, MD 23a. Part1. Enter the disease, or complications that visused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause of such line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yan 2 No 3 Probably 4 Unknown structum Records, ð 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Vio Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Inpatient 2 ER/Outpatient 3 DOA this he Hospital or Attending Physics 24 hours after death.

The Funeral Director: After this pietely filled in by the funeral directions and the funeral directions. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the 29a. Certifier To the Hosp within 24 hor To the Fune completely fi iner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) NON 1885 21157 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll County General Hospital 200 Memorial Ave. M.D.

State Registrar

31. Date filed (Month, Day, Year)

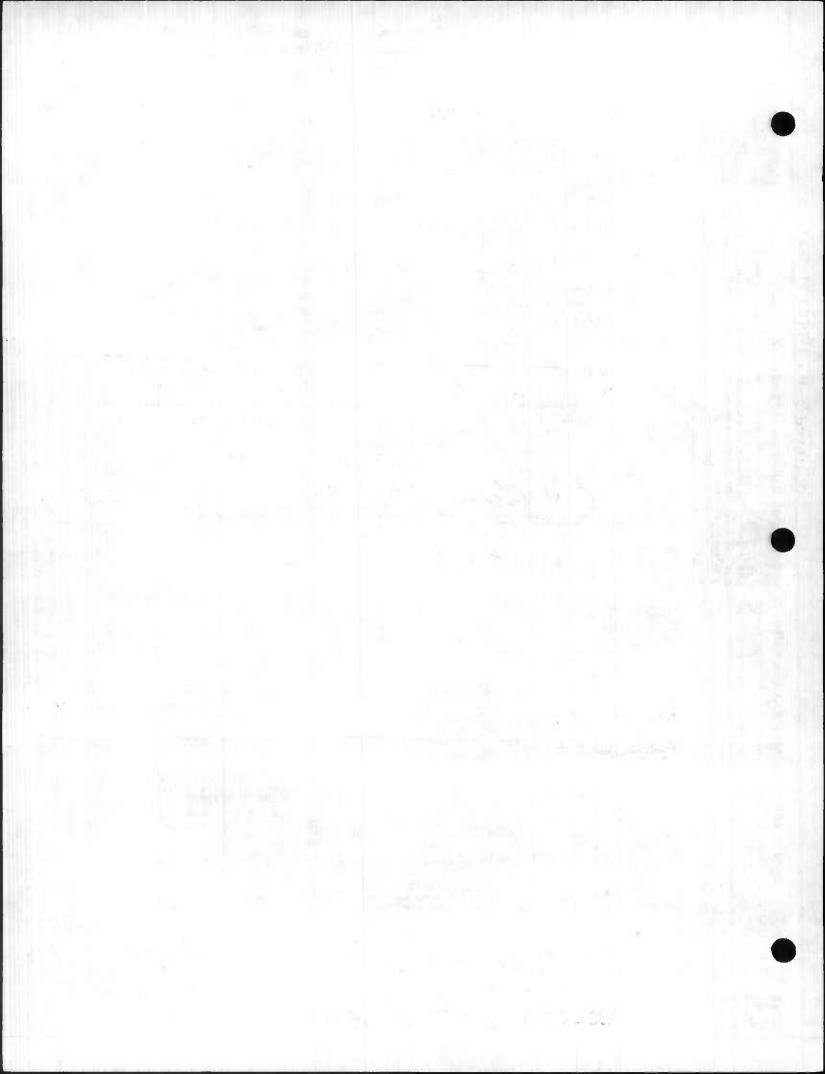
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AUG 1 0 1999

32. Registyer's Signature

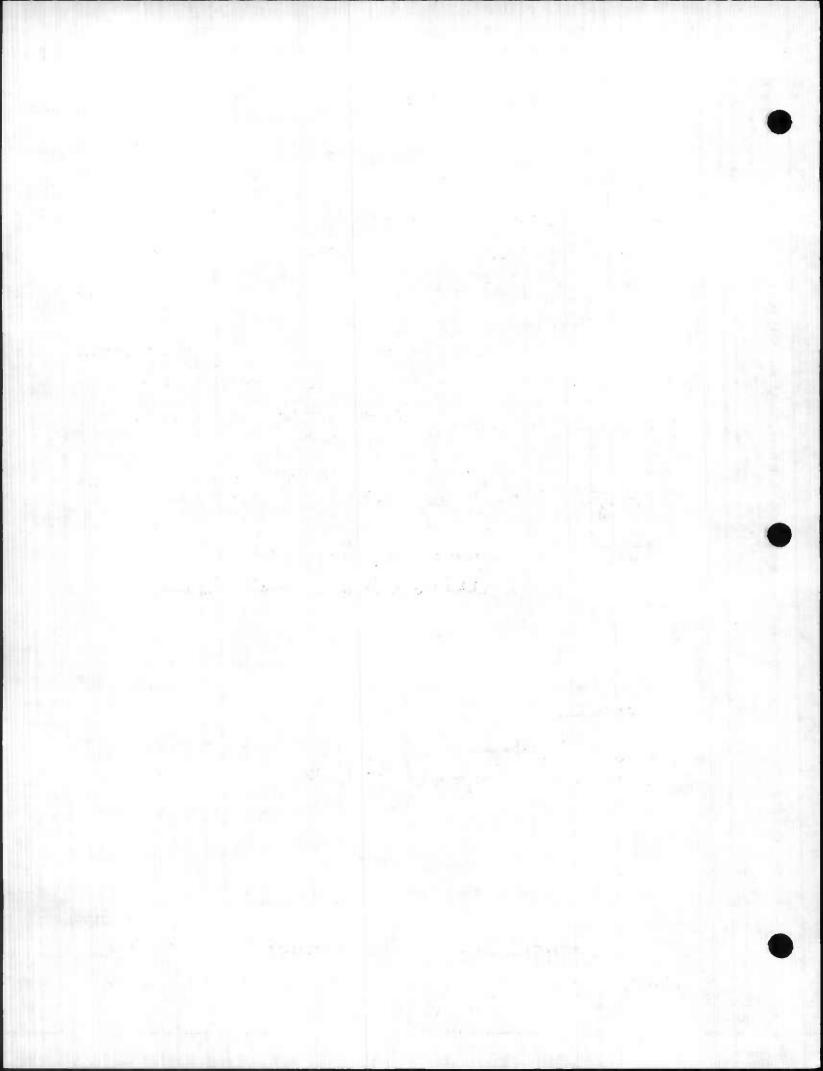
Tames R. Myers

Westminster, MD



State of Maryland / Department of Health and Mental Hygiene 9 9 267 1

				Certificate of	Death	Re	ig. No.	lin	0711
	Physician	Decedent's Name (First, Middle, Last) VIRGINIA TURNER	MITCHE	LL		2. Date of Deat Month	Dey	Γ Year 999	3. Time of Death
	/Medical Examiner	4e Facility Neme (If not institution, give street end num	ber)		4b. City, Town, or Lo		4c. County		2:00AM
	Examine.	9209 Mitchell Road			La Plata		Charl	es	
	Funeral	5. Social Security Number 6. Sex 7	7. Age (In yrs. last i	birthday) If Under 1 Year Months Devs	ff Under 24 Hrs.	8. Dete of Birth (Month, Day,			ace (State or Foreign
	Director	220-26-4506 1DM 2XF	93	Yrs.			1906		
	D B ss	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, To	own or Location				10	d. Inside City Limits
	Mary Heats fled a	MD Charles	To	Plata					1 ☐ Yes 2X No
	or 2ta-f a be notified Director	10e. Street and Number	La	10f. Zip Code		10	Og. Citizen of W	hat Count	ny?
		5477 Washington Ave.		200	646		USA		
	0 2 M E	11. Meritel Stetus 12. Wes Decer Armed Fort	dent Ever in U,S.	13. Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe en, Mexican, Puerto	city Yes or No- Rican, etc.)		- America	
21215-0020	by Exp.	1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Yes 3 Wildowed 4 Divorced Armed For 1 Yes Give Yes Give Yes or De	9	1□ Yes 2⊠No				Whi	
5	od within 72 ho ygjene. wr than "nahun t, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedent's Usuel Occup (Give kind of work done	during most of worki	ng	16b. Kind of Bu	siness/Indi	ustry
121	mpi m	Elementery/Secondary (0-12) College (1-		life. DO NOT use retire	od)				
9		17. Father's Neme (First, Middle, Last)		Secretary	18. Mother's Neme		Motor		any
Maryland	feetal Private of the see of the	John Frank Turner			Mary Ran				ner
ary	Mon Man	19e. Informent's Neme/Reletionship (Type, Print)	19	9b. Meiling Address (Street				_	
ž	alith a 27 is r tra	Hugh M. Mitchell.Jr.	/Son	P.O. Box 72	22 La Pl	ata,MD	20646		
ore	A House	20e. Method of Disposition	20b. Plece	of Disposition (Name of tery, cremetory or other pla	100)	Dete 2	20c. Location - (City or Tov	vn, Stete
altimore	Pages nett of ant: If the any or o	1 XBurial 2 ☐ Cremetion 3 ☐ Removel from S 4 ☐ Donetion 5 ☐ Other (Specify)	Mt.	The second second second		/18/99	La Pl	ata,	MD
Jalt	emit. Sparts sy injuries	21. Signature of Funerel Service Licensee	W0081	7 22. Name and Addre	ECHOLS				
Ш	20118	Hautin Clah	TIT	P.O. BOX	X 567 LA	PLATA	MD 20	646	
		23a. Part1. Enter the piseese, or complications that ca shock, or heart failure. List only one cause on ea	used the deeth. De	o not enter the mode of dyi	ng, such es cardiec d	or respiretory erre	est,		Approximate Interval Between
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8	/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) a.	andro-	Cesmenton	Unest				
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	executed in and ial-transit Examiner	Secure tieth tiet assetting	Duato for as	e consequence of):	- I-teach	سل	mu		
o,	exec an an rial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due 10 (01 es	e consequence ory.				1	
68760,	death certificate be executed e attending physician and of for use as the burfal-transit sician/Medical Examir	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es	s consequence of):					
39)	E 0 5							1	
Box	attendir for use	d							
	at the death ce d by the attendia etached for use Physician/I	Part II. Other significant conditions contributing to dea	ath but not resulting	In the underlying cause gi	ven in Pert I.	23b. Did to	V	tributs to	the cause of death?
P.0	that the de detached detached	1 Lementea				1 🗆 Yı	18 2E No	3 Prob	ably 4 Unknown
of Vital Records,	8 88 6	(1) (1)				24a. Wes at	autopsy	24b. We	re autopsy findings
COL	7100	Lyss thyudis	<u> </u>			perform		con	ilable prior to apletion of cause eath?
Re	The law ate has b page 2 s	5 M O A N		0 11.	1-	1□ Ye	s 2 No		Yes 2 No
tal	certificate rector, pag	25. Wes casa referred to medical	your	me orden	26. Place of Death				
2	Physician: this cartific ral director. To Be (examiner? Hospitel:	patient 2 ER/0	Outpatienf 3 DOA Ot	hor	me 5 Reside			ouse ters
0	5 5 5	27. Manner of Deeth 28a. Date of		Time of 28c. Inju		28d. Describe ho			LEIS
10	Attending Phirdeath. ctor: After thiby the funeral	2 Accident investigation	, 50, 101,		Yes 2□No				
Division	ual or Attending P rs after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca c building	of Injury - At home, g, etc. (Specify)	ferm, street, fectory, office		281. Location (St. City or Town		er or Rural	Route Number,
	rai Delli								
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Xertifying Physician: To the besone 2 Medical Examiner: On the besone	sls of examinetion a						
	within To the comple	29b. Signature end title of certifier	or ordered.	29c. Licens	se number	29	d. Date signed	(Month, L	Day, Year)
	F 3 F 0	1 7 1 - 12	n		01009				
		30. Name and address of person who completed cause	of deeth (Item 23a	(Type, Print)		į.		1	
		HENRY L. Burke M.	D. P.O.	Box 25.39	La Pla	ta mi	8-16	046	
	State		glatrer's Signetura	6 1					1.7
	Registrar	· AUG 1 6 1999	The second second	KT. Kora	AC 1				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Yea Agnes Clarissa Miller AUGUST 1999 19:00 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth CUMBERLAND ALLEGANY 8. Dete of Birth (Month, Dey, Year) Sep 7, 1912 If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) W Deys Months Hours 1□M 2□F 86 Yrs 10c. City, Town or Location 10b. County 10d. Inside City Limits Yas 2 No Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 21502 USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Rece - Amarican Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Giva Yaer or Datas: 1 Yes 2 No Specify: Specily: white 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surnama)

Examiner MEMORIAL HOSPITAL 5. Social Security Number 232-54-2535 Usuel Residence of Decedent 10a. Stata Directo MD 10e. Street and Number 627 Elm Street 100 11. Maritel Stetus 1 Never Merried 2 Married à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) 17. Father's Neme (First, Middle, Last) 88 nfn Ethel Shepherd 19e. Informent's Neme/Ralationship (Type, Print)
Vernon R. Miller 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 627 Elm Street; Cumberland MD 21502 husband 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 8/10/ Cumberland, MD 21. Signeture of Funeral Service Licenses 28 Carpel Fineral Home P.A. Cumberland, Maryland 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finet diseasa or condition resulting In death) 2 weeks CEREBRAL HEMORRHAGE Due to (or es a consequenca of):

Physician /Medical Examiner

requires that the death certificate be executed

ō ed by the a

signed by t

peed

has page 2

funeral director,

After this

 Hospital or Attend
 24 hours after death
 Funeral Director: / filled in by

To the Vithin 2

þ

Completed

Certification: To

Medical completely

Division of Vital Records, P.O. Box 68760.

AGNES MILLER

Physician

/Medical

Funeral

Director

notifie

r than "natural", or items 23s or the Medical Examiner must be

Pages 1 and 2 should be filled within ment of Health and Mental Hygieru. ant: if Nem 27 is marked other than "I ury or other traumatic event, the Mes

riment:

the Manter

72 hours after

Baltimore, Maryland 21215-0020

Examiner physician and s the buriaf-transit Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or thiury that initiated events rasulting in death) Last Physician/Medical USB 85

Dua to (or es a consequence of): Dua to (or as a consequence of)

AUGUST 10 , 1999

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown HYPERTENSION, DIABETES MELLITUS 24a. Wes an eutopsy performed? Wara autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only ona)

1 Ves 2 N	0	Hospitet: 1 Inpatient 2	ER/Outpatient	3□	DOA Othar: 4 Nurs	ing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Neturel 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury et Work?	28d. Dascribe how injury occurred
3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined		oma, farm, street	t, fact	ory, office	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
4 Homicide	1	building, atc. (Speci	(y)			City or Town, Stete)

11 Certifying Physician: To tha best of my knowledga, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Deta signed (Month, Day, Year) 29b. Signetura and titla of certifie

D33280

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

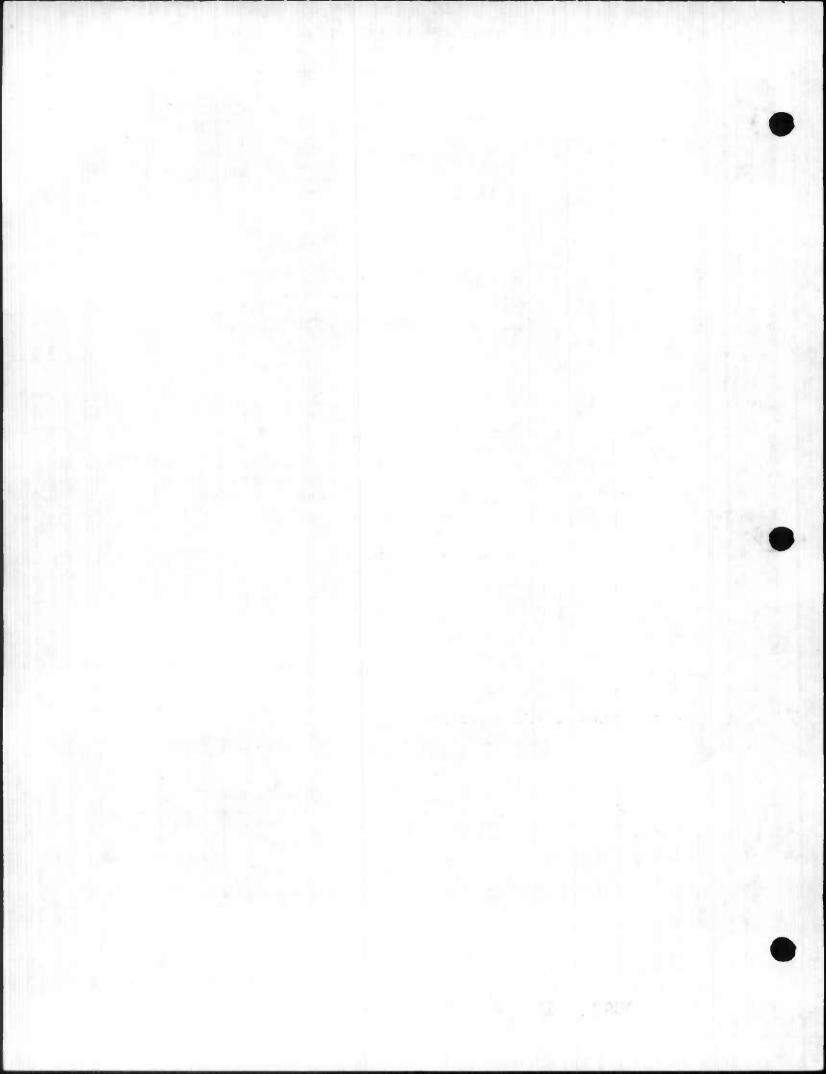
SUNIL K. GUPTA, MD 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

State Registra

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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended #23a & Part II. State of Maryland / Department of Health and Mental Hygiene NLS, Allegany Co., 8/11/99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Aug 8, Day 1999 Yeer 08:05pm McMillan Mildred /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Nursing Center Cumberland Allegany 5 Sociel Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth Mar 29, Year) 1910 9. Birthpiaca (Stata or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TF Days 89 217-10-6796 Vrs Director Usual Rasidance of Dacadant the Maryland 10a Stata 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be notified at 10d. Insida City Limits Director 1 XYas 2 □ No Allegany Cumberland 10a. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 717 Montgomery Avenue 21502 USA Funeral deeth 12. Wes Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ Yo if Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, atc. should be filed within 72 hours efter and Mentel Hygiene.

marked other than "natural", or ite 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas A ☐ No Specify: þ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) Bead Room Tire Company permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is merked othe any Injury or other traumests 17, Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surnama) William W. Sterner Edith Meyers 19a. Informant's Name/Ralationship (Type, Print) Eleanor Proudfoot Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
6 Warwick Avenue; Cumberland, MD 21502 406 20a. Method of Disposition 20b. Placa of Disposition (Name of camatery, cramatory or other placa) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Par8/11/ Cumberland, MD 21. Signature of Funeral S 22Scarbers Faruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that crused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arreat, shock, or heart failure. List only one ceuse on each line. Onset and Death Physician /Medical Immediete Ceusa (Final 2 week disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed pue Sequentially list conditions, if any, leading to Immadiata ceusa. Enter Underlying Causa (Disease or Injury that Initiated evants resulting In death) Lest the buriel physician Box 68760 Parkinson's Disease Physician/Medical Due to (or as a consequence of): ettending g 98 P.O. I signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to Be Completed 24a. Was an autopsy been completion of cause of deeth? page 2 s 1 ☐ Yas 2 ☐ No certificate Vital Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical letely filled in by the funeral director; to the funeral director; to the funeral director; to the funeral director. 25. Was casa rafarrad to medical 26. Piece of Death (Check only ona) examiner? Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 Alo Certification: To Jo 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division 1 Netural 2 ☐ Accident 5 Pending Invastigation 1 Yes 2 No 6 Could not be 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Cartifiar 1 Decertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(a) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stetad. To the Hospi within 24 hou To the Funer completely fif Medical (Check only onel 29b. Signature and title of ced 29d, Deta signed (Month, Dey, Year)

PODB/ NAS

State Registrar 31. Date field AUG

30 SCHEY ST

Camberland, Ad.

Date fied AUG 1 1999 32 Aggistrar Signature 5.



Amonded # 20c, Mdd, 8/11/99 Allegamy Co

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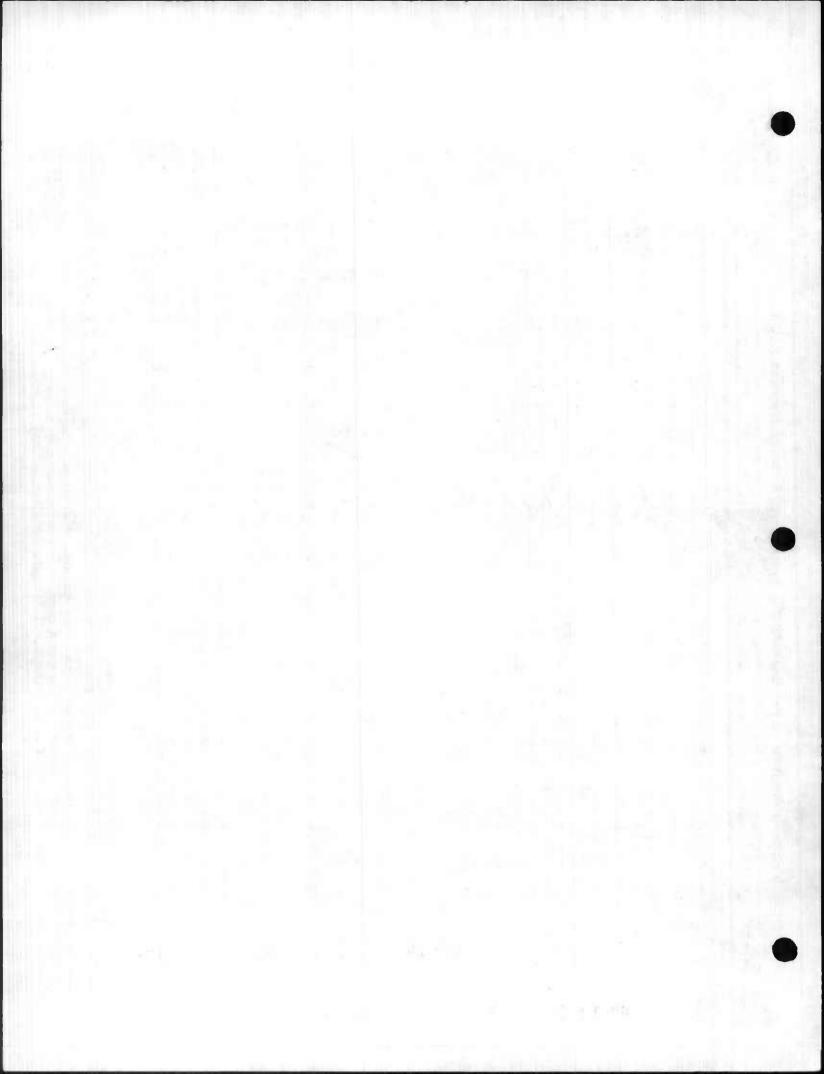
State of Maryland / Department of Health and Mental Hygiene o

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21215-0020	urs after al', or he	by Fur	1. Marital Slatus 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 It Yes, Give Year or Detes:	No		as Decedent of H Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)		Race - Amer Black, White Decily: WH	
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Bal	permit. Pa Departmen Important: any injury once.	1	21. Signature of Fu	unerel Service Licer	Jachus	2	UP		FUNERAL	HOME, IN		26719	
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	Physician		- (M-2) (B)		(1	2 -			/	7-			Onset and Death
	/Medical Examiner	- 0	mmediate Cause disease or condition resulting in deeth)	(Final on	a	DI	on	Choa	luce (arci	worm	a	2 yes
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ă	after din t	Certification:	4 Homlcide	Gotominos	building, et	c. (Specify)				City or To	wn, State)		
	To the Mospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha comparely filled in by the funeral director, page		29a. Certifier (Check only	12 Certifying Ph	ysician: To the best niner: On the basis o	of my knowledge	e, deeth o	occurred et the ti	me, dete end ple	ice, and due to the	cause(a) an	nd manner as	stated.
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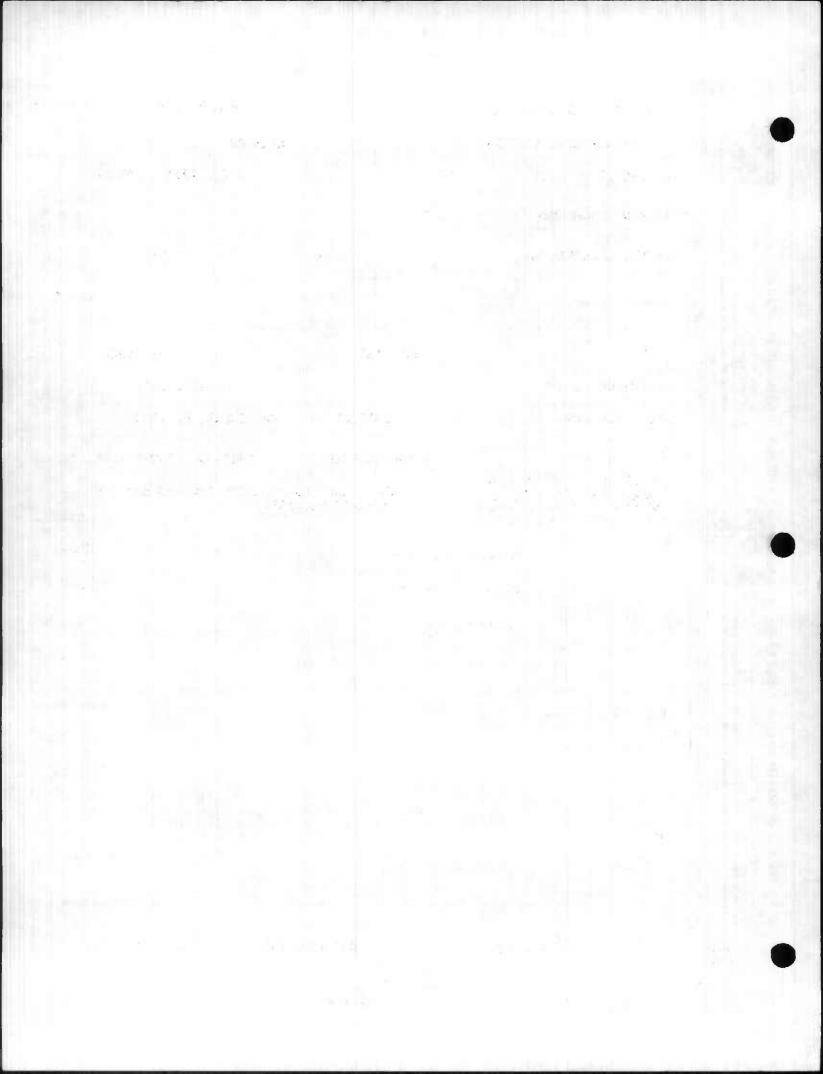


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Dev Month Year **Physician** 9:25 PM August 09 WALTER WILLIAM MILLER 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b City Town or Location of Deeth 4c. County of Death Examiner N/A UNION MEMORIAL HOSPITAL BALTIMORE Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□ M 2□ F XX Months Deys Hours Director 87 OCT 1 1911 PENNA 170-12-6412 Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23e or 28a-f shov the Medical Examiner must be notified at HARFORD MARYLAND 1 TYes AT No **JOPPA** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 PHILADELPHIA RD 21085 USA Funeral death 12. Was Dacedant Evar in U.S. Armad Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Bleck, White, etc. hours after 1 Never Merried 2 Married Yes 2 No Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Nidowed 4 Divorced Yaar or Detes: Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry filed within 72 al Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) MECHANIC **AEROSPACE** permit. Pegas 1 and 2 should be filk Department of Haalth and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) Be RICHARD MILLER MALINDA MILLER 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17 REDFIELD CT, BALTIMORE, MD 21236 VICTOR MILLER/SON 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1

☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State UNION CEMETERY 8-14-99 CENTERVILLE, PENNA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility DALLA VALLE FUNERAL SVC INC, PO BOX 179 23e Pentl. Enter the disaesa, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or raspiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onsat end Death **Physician** /Medical Immediate Ceuse (Final 2 hrs a Hemorrhane shock diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner 3 weeks Myocardid infaicken the death certificata be executed and tha buriel-tran Sequentially list conditions, if any, leeding to immediate ceuse. Enter Undarlying Ceuse (Diseese or Injury Due to (or es e consequence of) P.O. Box 68760, Cardia mys patty
Due to (or es e consequence of): attending physician for usa as tha burie Physician/Medical that initieted events resulting in deeth) Last Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Tyes 2 No 3 Probably 4 MUnknown Prevenal azetemia Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy Completed Congestive Heart failure peen performed has paga 2 1 Yes 2 No 1 Yes 2 No certificata Division of Vital Be 25. Wes cesa referred to medical 26. Piece of Deeth (Check only one) exeminer's Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Aftar this 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of or Attanding 1 Netural 5 Pending Investigation s after daath. 1 Yes 2 No 2 Accident In by tha 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled Ir 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only onel 29b. Signatura and fitla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) AT 2438946 August 09, 1999 12 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) Johnson M.D. Union Memorial Huspital nu 31. Dete filed AUG 32 Segistrarie Signeture State

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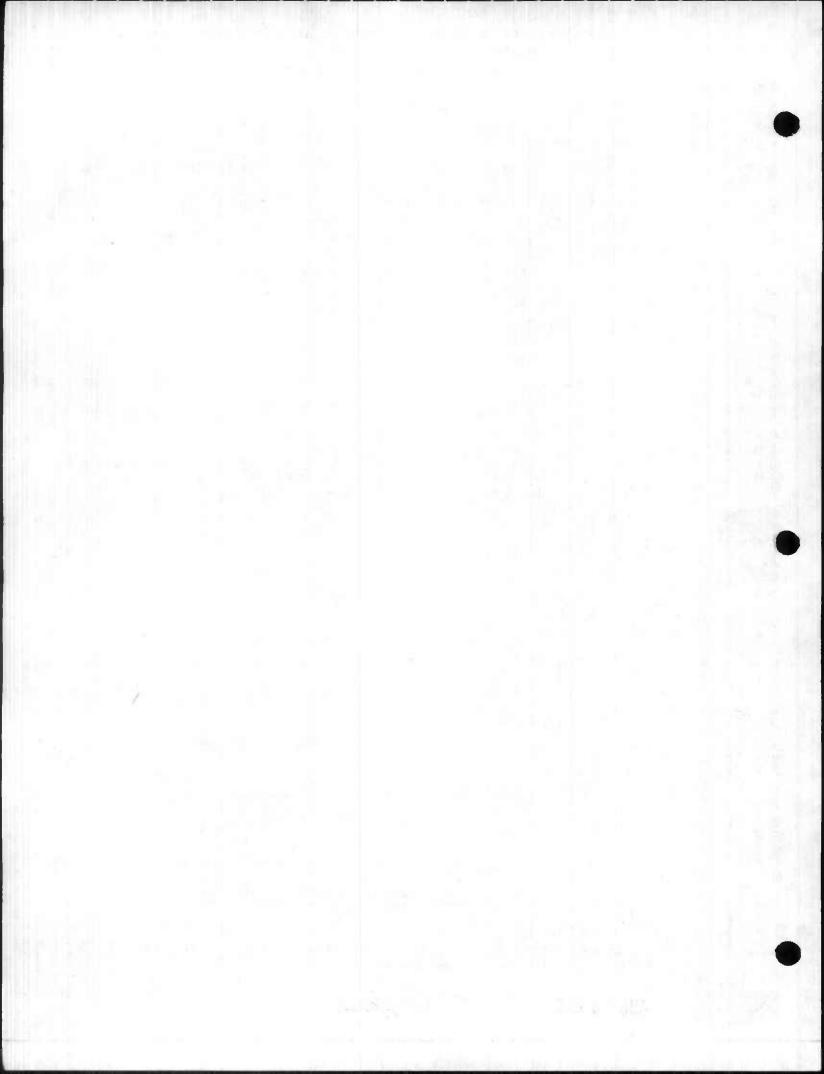
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State of Maryland / Department of Health and Mental Hygiene 9 9 267 | 6

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/Medic	cal	Genevieve 4a. Facility Name (If not Institution, gi			Magr	uaer				ocation of Deal	11,	Dounty of Dea	
Formand		Cumberland Nu 5. Social Security Number 6.	rsing Sex	Home 7. Age (In yrs.	last birthday)	if Under	1 Year	Cumbe			rth		legany
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death with the Maryland ms 23s or 28s-f show	al Dire	10e. Street and Number 37 Second Ave	nue			10f. Zip	Code	26	753		_	en of What Co	ountry?
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n 72 hours "natural", edical Exp	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)) [16a. Deced	dent's Usua kind of wor	l Occup	pation during most	of work	ding	16b. Kin	d of Business	/Industry
filed within Hygiene. other than	ошо	Elementary/Secondary (0-12)	College ((1-4or 5+)	Home			,u)			Own	Home	
od al	To Be C	17. Father's Name (First, Middle, Las Chester Kifer	t)					18. Mother		e (First, Middle (Ki	, Maiden S nser		
		19e. fnforment's Name/Reletionship Robert H. Mag			19b. Mailin 37 S	econ	(Street	end Numbe	or or Rur	ral Route Numb	oer, City or	Town, Stete,	Zip Code)
permit. Pages 1 end: Department of Health Important: If item 27 eny Injury or other tr		20a. Method of Disposition 1 Durlai 2 Cremation 3 Dother (Speci	ity)	State	22	st M Scar	emo peri	rial	ine	r8/13/ ral Ho	Cum		Town, State
Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		tastat Due to (or									Approximate Intervel Between Onset and Death
leath certrificate be executed ettending physicien end for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	b	Due to (or	as a consequence as a consequence	uence of):		7					
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Within To the comple	N V	29b. Signature and the of certifier	Jing man	312160.		29c.	. Licens	se number			29d. Date	signed (Mon	th, Day, Year)
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6 Mas		30. Neme end eddress of person who Sunil K. Gupt	completed caus							and MD			

Registrar



99-4642-001 CJPlease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Gary Jerome State of Maryland / Department of Health and Mental Hygiene Q Q Minnick
AMENDS: ITEMS: #23 PART I, 27 PER MEO G775 9-9-99 WR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 09 1999 11:03 AM. August Gary J. Minnick 4a Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany ff Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 10 M 2□ F 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 213-06-2503 04-Apr-69 Maryland Usual Residence of Deceder the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 288-1 Maryland Allegany Frostburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? WITH Name 25s or iner must be b 11609 Dobbin Drive, N.W. Funeral U.S.A. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 72 hours after ental Hygiene. od offser than "natural", or Its c event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 heavy equipment operator coal minina 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) 89 Pages 1 and 2 should be nent of Health and Mental Robert Minnick Isabel Caton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If flem 27 is any injury or other trau ance. Robert Minnick Father 20b. Place of Disposition (Name of cametery, cremetory or other place) Frostburg Maryland 21532-20c. Location - City or Town, State 20a. Method of Disposition
1 DiBurial 2 Cremetion 3 Removel from State 4 Donation 5 DOther (Specify) Finzel Cemetery 13-Aug-99 Finzel, Maryland 21. Signature of Funeral Service Lice 22. Name end Address of Facility Kluri blu. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Past. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel CARDIAC ARRHYTHMIA ASSOCIATED WITH MYOCARDIAL FIBROSIS disease or condition resulting in death) Examine Due to (or es a consequence of): Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) physician s the burie Box 68760. Physician/Medical Due to (or as a consequence of) 80 for Use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown signed I Records. þ been signature 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 has Yes 2□ No Yes 2 No certificate Division of Vital Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 DXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending investigation 1 Ø Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 ☐ Suicide 6 ☐ Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide 8 filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifie edicai (Check only one)

8 State

Registrar

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Stephen
31. Date filed (Month, AUG 1 6 1999

Radentz 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 10, 1999

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		give street end nu MEMORIA		SPITAL				wn, or L	ocation of Dea		y of Death ARRET	'T	
5. Social Security 179–14–5		6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. lest birthdey) Yrs.	If Undar Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D OCT 3	irth ay, Year) L, 1922	9. Birthplaca (Stata Country) PA		
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	Name/Raiationsh	ip (Type, Print) DAUGHTER	2		ng Addrass BOX				TER'S,	ber, City or Town	, Stata, Zip		
20a. Mathod of D 1 ☐ Buriai 4 ☐ Donation	cematary, crai	Place of Disposition (Nama of ematary, cramatory or other placa) CGA CREMATORY 8/6/99 MORGANTOWN, WV											
21. Signature of	Funeral Service L	icensee	1	2:	2. Neme er	nd Addre	ss of Facili	ly	P.O.	BOX 243			

Physician /Medical Examiner

Department of important: If any injury or 9

other t

Director

Funeral

by

Completed

Be

Physician

* /Medical

Examiner

Funeral

Director

Pages 1 end 2 should be filled within 72 hours after death with the Marylend nent of Heatth and Mental Hygiane. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Hygiane.

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Marical Examiner must be notified at

physician end s the burial-trans requires that the death certificate be axecu 86 USB for the datached signed by 8 page 2 should peen or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical by Completed After this certificata has director, Be To funeral Certification: within 24 hours after death. To the Funeral Director: A filled in by

M00167 DURST FUNERAL HOME OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvel Batween Onsat end Deeth tmmedlete Cause (Finel disaasa or condition rasulting in daath) pneumonia 1 day Due to (or es e consequence of): Sequentieily list conditions, if eny, leeding to immadiete causa. Entar Undarlying Cause (Disaase or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of): Dua to (or as a consequence of):

23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yaa 2X No 3 Probably 4 Unknown dementia 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? compiation of cause of death? 1 ☐ Yas 2 🛛 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 ☐ Yas 2 📆 🔭 o 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 2 ☐ Accidant 1 Yes 2 No 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 1 Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifian (Check only one) 29d. Deta signed (Month, Day, Year) 29c. Licanse number 29b. Signetura end title of certifier

State Registrar

Medical

Walter

31. Dete filed (Month, Day, Yaar) AUG

K. Naumann,

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

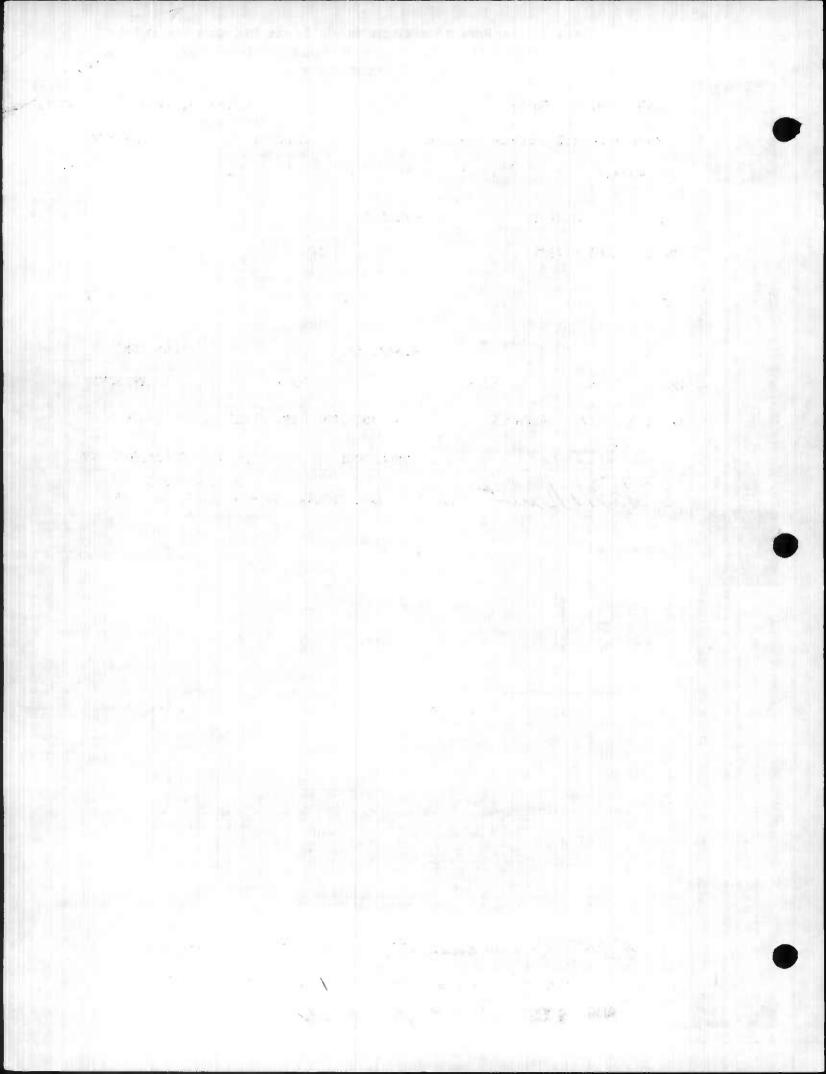




D25759

August 5, 1999

To the Hospital



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** KIRKWOOD SCOTT NEVIN, Jr. 1999 12:35 pm AUG 10 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street end number) Examiner 5230 Long Corner Road White Hall Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 100M 20F Months Days Yrs. 80 11/11/1918 Pennsylvania Director 210-09-2148 Usual Residenca of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 3€3No Director MD Harford White Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "naturel", or items 23s or treumstic event, the Medical Examiner must be 5230 Long Corner Road 21161 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces?

12 Yes 2 □ No If Yes, Give Year or Dates: WW 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black White etc. 72 hours after 1 Never Merried 2 X Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ WW II 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hyglene. Aircraft Design/ College (1-4or 5+) Elementary/Secondary (0-12) Design Engineer/Farmer 12 Beef Cattle 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) P Kirkwood Scott Nevin Wilma Damon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If them 27 Is m eny injury or other treum pace. Sally W. Nevin - Wife 5230 Long Corner Road, White Hall, MD Saltimore. 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Dete 1 ☐ Buriel 2 XI Cremetion 3 ☐ Removal from State Evans-Eagle Crematory 8/11 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 6 Funerel Servica Licenses 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Harkins Funeral Home, Inc., Delta, PA Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner MTIC PROSTATIC CANCANDMA Examiner certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or es a consequenca of): 50 USB ŏ 23b. Did tobacco uss contributa to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yss 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed peed has page 2 1 Ves 2X No 1 □ Vas 2 □ No certificate Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 52X Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐XNo his funeral 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Certification: After 5 Pending investigation DO Qaturel after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ծ n 24 hou. Hospital 24 hours a **Examiltying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of carrifier D23450 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 11.41 21131 Walter R. Hepner, M.D., 3346 Paper Mill Road, Phoenix, MD

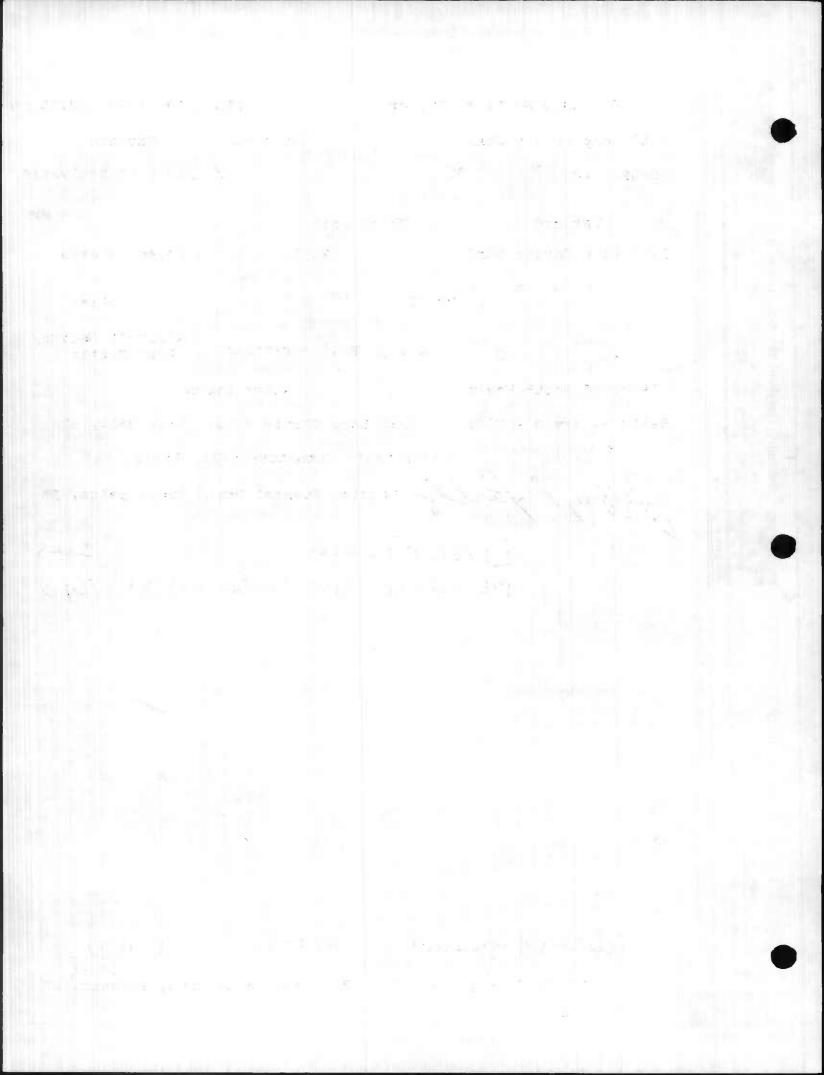
State Registrar

ay. Year)

1999

32. Registrer's Signature

Bagan se sons

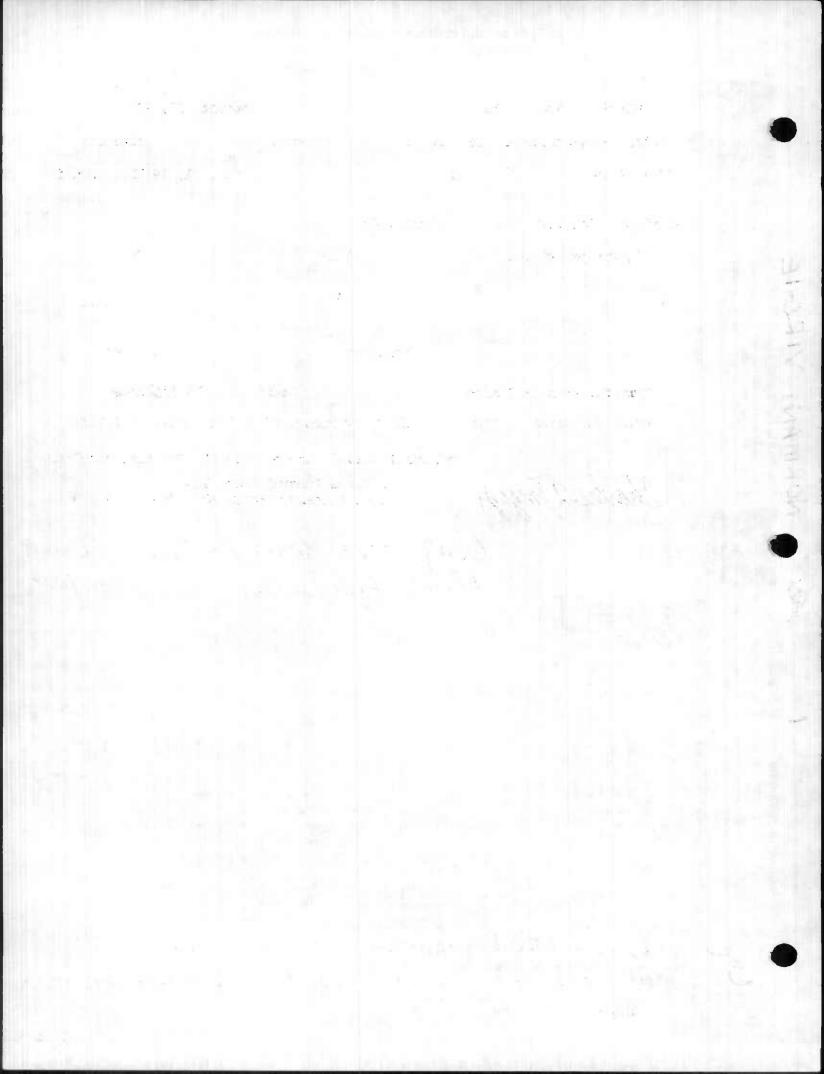


Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

Physician /Medical Examiner	1. Decedent's Name (F								2. Date of De Month			ime of Death
	Virgie Mae Norman									Day 10	Year	
Examiner								Ib Ciby Town or	August Location of Death	11, 19		
	4s Facility Name (If no								Location of Death			
	Dulaney-					7 1/11-4-		Towson			ltimore	
Funeral	5. Social Security Num		7 M 2DXF	. Age (In yrs.		Months Months	r 1 Year Days	If Under 24 Hrs Hours Min	. (Month, Da	th y, Year)	9. Birthplace (5 Country)	State or Foreign
Director	215-14-811	.8	101 2 220	81	Yrs.				Oct. 3	31, 1917	N. Caro	olina
	Usual Residence of De 10a. State 10	ocedent Ob. County		100 Cit	y, Town or L	onation					10d Inc	side City Limits
rector	Toa. State	Do. County		TOG. CII	y, Town or L	OCAHOH						
Director	Maryland	Harford	l	V	White	Hall						Yes 2½ No
- Sire	10e. Street and Number	er				10f. Zij	p Code			10g. Citizen of V	Whet Country?	
	3139 Dr	y Branch	Rd.				2116	1		U	SA	
Funeral	11. Marital Status		12. Was Deced	lent Ever in U	,S. 13.	Was Dece	dent of H	ispanic Origin? (5	Specify Yes or No to Rican, etc.)	- 14. Rac	e - American Ind	ian,
2	1 Never Married	2 Married	1 ☐ Yes 2	2 No					to Fican, etc.)		ck, White, etc.	
by	3 ☑ Widowed 4 □	Divorced	If Yes, Give Year or Dat			1 🗆 Yes	2 <u>M</u> No	Specify:		Specify	White	
Pe	15	. Decedent's Edu	cation		16a. Dece	edent's Usu	al Occupa	ation		16b. Kind of Bu	usiness/industry	
Completed	(Specify	only highest grad	e completed)	tor 5 · \	(Giv	DO NOT	ork done d ise retired	during most of wo	nking			
E	Elementary/Seconds	sry (U-12)	College (1-	+0(2+)	Hom	emake	r			Own	Home	
0	17. Father's Name (Fire	st, Middle, Last)						18. Mother's Na	me (First, Middle			
o Be												
2		Iontogome		ıns	105 14-1	ino Addres	o /Stmot	Jetti	e (u/k Jural Route Numb	Absch		
	19a. Informant's Name				-							
		D. Norma	n - So				M	anch Rd.	, White			alo.
	20a. Method of Disposi		emoval from S	tate	Place of Disp semetery, cre	ematory or	other plac		Date		City or Town, St	
	4 Donation 5			Bel	Air :	Memor	ial (Gardens	8-14-99	Bel Ai	r, Maryl	Land
	21. Signature of Funer	al Service Ligens	27		2	2 Name a	nd Addres	ss of Facility	Home, P.	Δ		
9	1/hans	00.11.1	MALL	1					Road, Abi		MD 21000	
20	23a. Part1. Enter the c shock, or heart fa	disease, or compl	cations that ca	used the deat	h. Do not er	nter the mo	de of dvin	g, such as cardia	c or respiretory a	rrest.		oximete
	shock, or heart fa	ailure. List only or									Interv	ral Between it and Death
an al	Immediate Cause (Fin	el		an	apc	40,	0	Hoar	t Fai	1	2	Ulare
ner	disease or condition resulting in death)			Con	TES	110	2	recor	Ta,	lure	1	Years Year
10				Due to (ras a conse	equence of)	1	11 10				Unar
al Examin)	HTTI	al	Fi	pri	11aTil	on		- 1	yeu.
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m	Sequentially list condit if any, leading to imme cause. Enter Underlyic Cause (Disease or Inju- that initiated events	ng iry										
edical	that initiated events resulting in death) Las			Due to (o	r as a conse	quence of)	:					
90												
ary												
SIC	Part II. Other significan	nt conditions cor	tributing to dea	th but not res	ulting tn the	underlylng	cause giv	en In Pert I.	23b. Did	tobacco use co	ntributa to the c	ause of death?
Physician									10	Yes 2□ No	3 Probably	4 Unknown
by P												
D									24a. Was	an autopsy	24b. Were eu	topsy findings
ete									perto	ormed?	evaileble completion of deeth	on of cause
Completed										do a	-	
ပ္ပ									1 🗆	Yes 2 No	1 Yes	2 No
Be	25. Was case referred examiner?	_	1				100		eath (Check only	one)		
2	1 ☐ Yes 2 ☑ No	1	lospital:	patient 2 🗆	ER/Outpation			4 Minursing	Home 5□Res			
	27. Manner of Death	5 Pending	28a. Date of	Injury , Day Year)	28b. Time Injury	of	28c. Injur	y at k?	28d. Describe	how injury occur	ber	
atic	1 Monatural 3 2 ☐ Accident	5 ☐ Pending investigation	,	, ,		М		Yes 2□No				
HIC		6 Could not be determined	28e. Place	of Injury - At he	ome, farm, s	treet, factor	ry, office		28f. Location (City or To	Street and Numb	ber or Rural Rout	le Number,
أالسو	4 Homicide	The state of the s	buildin	g, etc. (Specif	y)				City of 10	m, olale)		
i d	29a. Certifier 1	Certifying Phys	Iclan: To the h	est of my kno	wledge, dee	th occurred	et the tin	ne, date and plac	e, and due to the	cause(s) and me	enner as stated.	
al Cer	(Check only 2	Medicat Exami	ner: On the bas	is of examine	tion end/or i	nvestigation	n, in my o	pinlon, deeth occ	turred at the time,	dete and pleca,	and due to the c	ause(s)
dical Cer	one)	^	A A	1		29	c. Licens	e number	T	29d. Date slone	d (Month, Day, 1	(ear)
medical cel		a/of dertifier										
יייייייייייייייייייייייייייייייייייייי	29b. Signature and titte	of dentifier	Hond'	no DL	100		2	2/100		1	2 1998	
Medical Cer		of dentifier A	tend:	ng Ph	15: Ci	an	D5.	3642		Aug. 1	2 1998)
Medical Certification:		In A	Hend's	of death (Item	15. Ci	an Print)	D5.	3642	D	Aug. 1	2 1998 P 1-	tinen-
Medical Certificat	29b. Signature and title	Sof person who co	tendi empleted cause 2HOU	ng Phod death (Item	15, Ci 23a) (Type 007	an Print)	D5.	3642 rther	n Par	Aug. 1 K Way	2 1998 Balt	timore

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Yea **Physician** Jerusha Mitchell Oliver August 10, 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 634 Burkley Avenue Aberdeen Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Hours 1 M 20 F Months Director Oct. 3, 212-56-3126 Maryland Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Merylend nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural; or frems 23s or 28s-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23s or 28s-f show edical Examiner must be notified at 1 XYes 2 □ No Directo MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 634 Burkley Avenue 21001 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Biack, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed marked other than "natur imatic avent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Malcolm Walker Mitchell Eva Gertrude Osborn 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles M. Oliver (Son) 300 Patterson Mill Road, Bel Air, MD other Hem 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it sny Injury or o 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/99 Grove Presbyterian Cemetery Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that ceused abock, or heart failure. List only one cause on each the Approximate Interval Between Onset and Death **Physician** MYOCARDIAL INFARCTION /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably Vunknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? peen certificate has b alxino 1 Yes 1 Yes Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director. Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2DNo Other: 4 Nursing Home Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Manner of Death 28b. Time of Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

ath (Item 23a) (Type, Print)

State Registrar 0. 1. 4.9

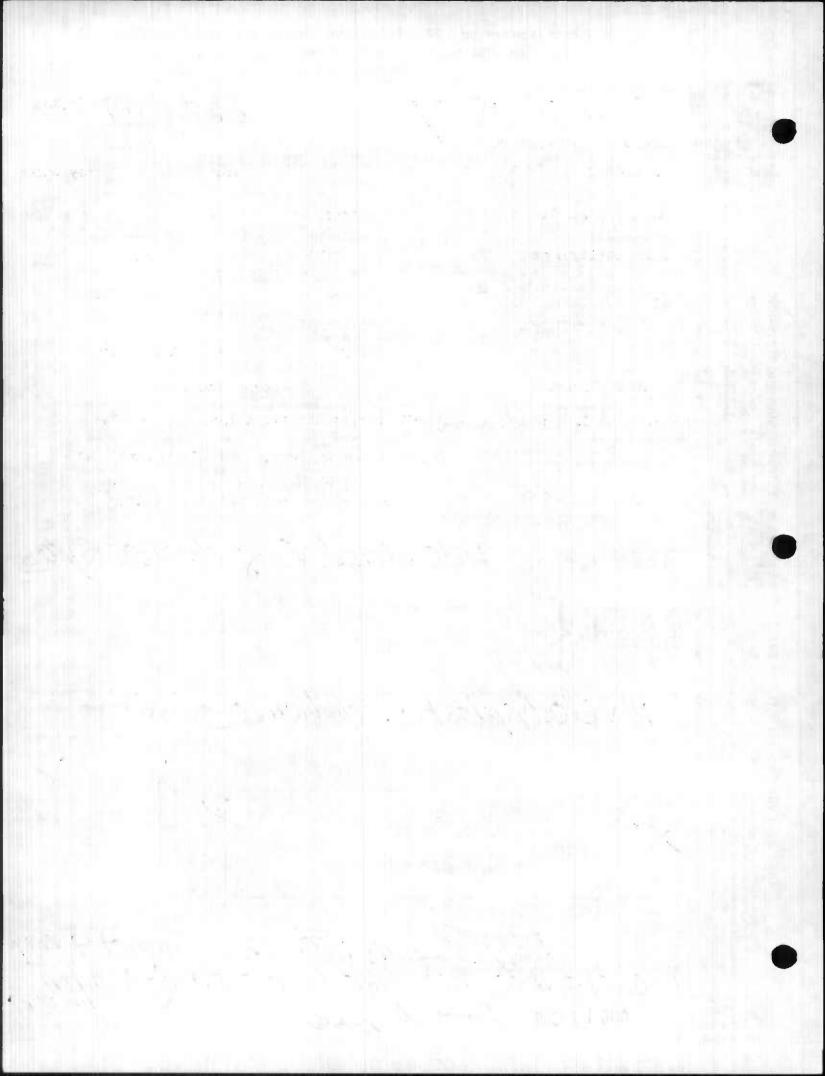
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30am /Medical 4b. City, Town, or Location 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner 5875 Springmount Court Eldersburg Carroll Date of Birth (Month, Day, Year) Mar 20, 1907 If Linder 1 9. Birthpiaca (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Hours Min 1□M 20 F 92 112-09-8362 Yrs. **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Meryland ment of Health end Mental Hyglene. The file of th 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Eldersburg 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5875 Springmount Court 21784 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No White Baltimore, Maryland 21215-0020 Specify: þ 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care LPN 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alva Davies Mazie Schvrock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Sarah J. Hajduk (DAUGHTER) 5875 Springmount Ct. Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cramation 3 Ramoval from State Carroll Cremation Serv. 8/10/99 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (BOX 195) 21. Signature of Funeral Service Licenses Sykesville, MD 21784 (410)-795-1400 23a. Part1. Entar the disease, or complications the studed the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause to each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or es a consequance of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 980 23b. Did tobacco use contribute to the ceuse of death? ing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown signed I þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? irector, page 2 s or Attending Physician: Be 25. Was case registo medical 26. Place of Death (Check only one To Other: 4 Nursing Home t Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 DOther (Specify) this funeral Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) After 5 Pending investigation Nanoral 2 🗆 No 1 Yes efter deeth. Director: A 2 C. Applicant 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 31 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. 3 4 C Homicide **Dertifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 To the the th Date signed (Month, Day, Year) 29b. Signature and title of cartifie 29c. License number

State Registrar

31. Date filed (Month, AUG 1 1 1999

Name and address of person who q

Registrer's Signature

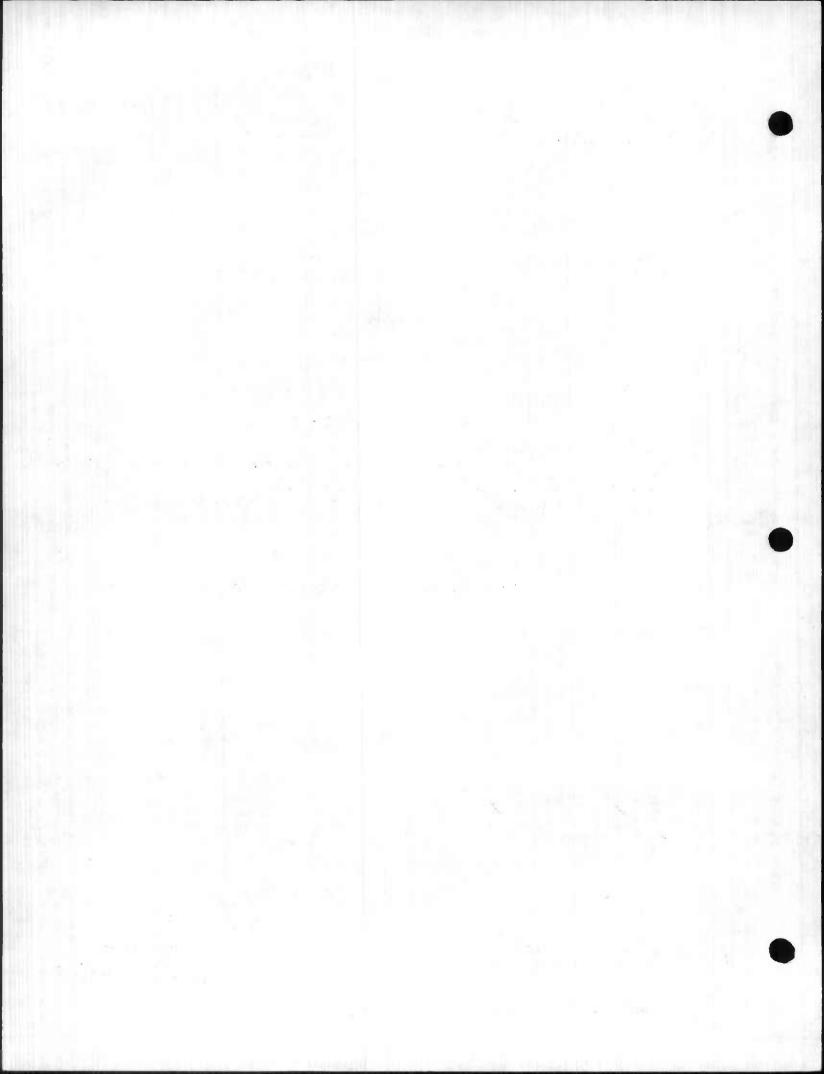


Physician	1. Decedent's Neme (First, Middle, La					2. Date of Month	n Day	Year	3. Time of Death		
/Medical	GRANT LEO RUB	Y SR.				Augus	st 10	1999	17:40 PM		
Examiner	4a Facility Neme (If not institution, git MEMORIAL HOSPITA				4b. City, Town	n, or Location of I LAND		y of Death			
Funeral Director			(In yrs. last birth	Months Day		Hrs. 8. Dete c Min. (Monti	of Birth h, Dey, Year) 7 1935	9. Birthple Count	ace (State or Foreign lry) PA		
show show ideal	10a. State 10b. County		10c. City, Town	or Location				10	Od. Inalde City Limits		
with the Marylar s or 28s-f show be notified at Director	PA BEDFO	RD	CLE	ARVILLE					1 ☐ Yes 2 No		
or 28e-f s be notified Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of	What Count	lry?		
acts as 250 must be need by a second	2109 FLINTSTONE				5535	-1-		S.A.			
72 hours after death with the Maryla natural, or liens 23s or 28s-f sho disal Examines must be notified at eted by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1. Types 2 No fi Yes, Give Year or Dates:		13. Wes Decedent of If Yes, specify C	uban, Mexican, I	Puerto Rican, etc	Speci	ce - America eck, White, e			
72 ho fical i	15. Decedent's E	ducation	16a D	ecedent's Usual Occ	cupation	of working	16b. Kind of I	Business/Inde	ustry		
tal Hygiene. di other than "nature weart, the Medical. Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work dor ife. DO NOT use ret							
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nd Mental Hyg marked other amatic event, I To Be Co	HARRY FRANCIS RU	ВУ			BESSI	E HEAVN	ER				
Health and Mon tem 27 is manks other traumatic To	19a. Informant's Neme/Reletionship		19b. I	Aailing Address (Stre				n, State, Zip (Code)		
and z safth a er tre	HILDA I. RUBY	WIFE	210	9 FLINTSTO	ONE CREE	EK ROAD	CLEARVILL	E PA 1	15535		
ages 1 and 2 should be in rit of Health and Mental H it if item 27 is marked out y or other traumatic even To Be	20a. Method of Disposition 1 Burial 2 Cremetion 3 D	Damoual from State	20b. Place of D cemetery,	Disposition (Name of crematory or other p	olace)	Dete	20c. Location	- City or Tov	wn, State		
Departit. Pa Departmen Important any fillury any fillury	23a. Pert ¹ . Enter the disease, or comshock, or heart feilure. List only	enitt		22. Neme end Ack MERRITT—AI 404 DECATI t enter the mode of c	DAMS FUN UR STREE	ET_CUMBE	RLAND MAR		Approximate Interval Between Onset and Death		
/Medical Examiner	Immediata Cause (Finel disease or condition resulting in death)			CARCINOMA	OF LUNG			2	/1999		
ě			OBSTRIICT	nsequence of): :IVE PULMO	NARY DI	SEASE		ún	known		
Servincate be executed ding physician and se as the burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D	ue to (or as a co	nsequence of);	NAKI DI	JERUE			RHOWH		
d by the attending letached for use a Physician/M	Part II. Other significant conditions of	contributing to death but	not resulting in t	he underlying cause	given in Part I.	23b.	Did tobacco usa c	ontributa to	the cause of death?		
d by the detached							1 Yea 2 No 3 Probably 4 Ur				
Attending Physician: The law requires that the death certificated by the attending ector: After this certificate has been signed by the attending by the funeral director, page 2 ahould be detached for use a life funeral director. Page 2 ahould be detached for use a life attending the completed by Physician/Mi						24a.	Was an autopsy performed?	ava	ere autopsy findings allable prior to appletion of cause death?		
page 2	OK. P. L. C.						1□Yes 2₺No	1 🗆	Yes 212 No		
s certificate hadirector, page	25. Wes case referred to medical examiner?				26. Place o	f Deeth (Check o	only one)				
2 = -	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outp	atient 3L DOA		ing Home 5	Residence 6 🗆 O	her (Specify)		
leath. tor: After thi the funeral cation: 1	27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not by			M 1	☐ Yea 2 ☐ No		cribe how injury occu				
after death. Director: Ad in by the fi	4 Homicide determined	288. Place of injury	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		pysician: To the best of niner: On the basis of e and manner state	xamination and/								
With Common	29b. Signature and the of certifier	Jaren		D2	23371		29d. Date sign August				
ynes !	30. Name and address of person who Dr. Zaman, Johnson	completed ceuse of dee Heights Me	edical B	/pe, Print) 1dg., 625	Kent Av	enue,Cum	berland,	MD 215	502		
State	31. Date filed (Month, Day, Year)	62. Registrar	's Signature/	1							
	31. Date filed (Month, Day, Year) 93		's Signature/	Spark							

DHMH 16 Ray 6/95

215-34-4298

GRANT RUBY



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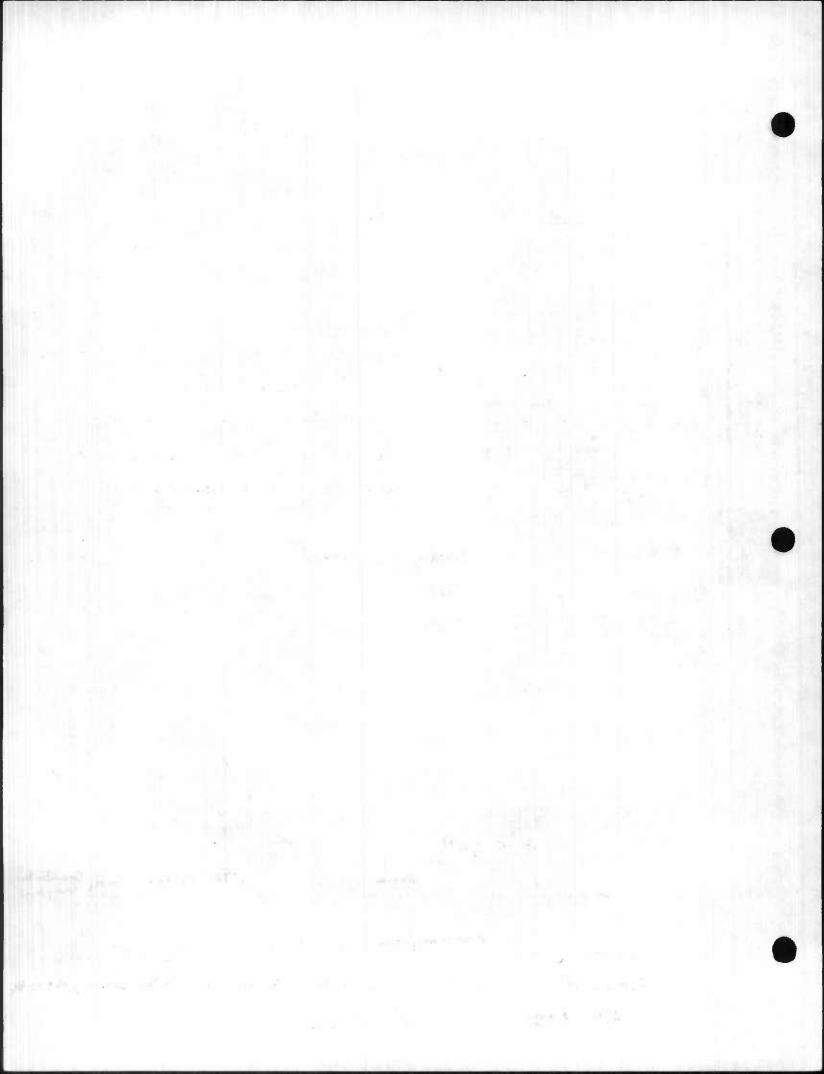
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Joseph Cortez Resh August 4, 1999 1806 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Cumberland Sacred Heart Hospital Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 10 M 2□ F 91 Director Aug 23, 1907 Maryland 212-18-1003 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 15925 Bittinger Road 20 21536 USA Nems 23s 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No if Yes, Give Yeer or Detes; 11. Merifai Sfefus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Merried 'natural', or 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) Fire Brick Manufacture 7 th Heavy equipment operator Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Simon Resh Harriet Wiley 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 15925 Bittinger Rd., Grantsville, MD 21536 Ruthella J. Resh/wife 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Grantsville Cem. Aug 8, 1999 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signefure of Fuperal Service Licensee 22. Neme and Address of Fecility Newman Funeral Homes, P.A., P.O. Box 275 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical cardiopen overt immediate Examiner Due to (or es a consequence of): Examine CHF physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, COPD 8 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown signed t by Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 20 No Certification: To this 27. Menner of Death 1 DiNatural 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Division Attending 5 Pending investigation Aug-17 4, 1989 death. 1 Yes 2 No Ne Hospital or Attendi n 24 hours after death. Ne Funeral Director: A sletely filled in by the fu 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hone 15925 Bittinger Road Grantswike 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29b. Signefure end fifle of certifier Phonony/com HOO53855 August 5, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Motgail, Do Sacrel that Hospital 900 seton DRIVE, MARYLAND stanky 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

Registrar **DHMH 16 Rev 6/95**

State

AUG



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney

26725

8. Serent ounty GARRET WE I Married orced bedent's Eduhighest grade	DEHEAVE street and nur X M 2D F 12. Wes Dece Armed Fo 1 M Yes, Gh If Yes, Gh	7. Age (In yr 77	City, T	Yrs. Yrs. Yrs. Yrs.			GRANT	SVIL	8 Date of Bir	C 6, 199 4c. County GARRI	of Deeth		of Death 36 PM	
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highest grad	11. Merital Status 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent Ever in U,S Armed Forces? 14. Wes Decedent Ever in U,S Armed Forces? 15. Secondaries Education (Specify only highest grade completed)				Was Decede f Yes, specif				ecify Yes or No Rican, etc.)		14. Race - American Indian, Bleck, White, etc. Specify: WHITE			
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{	b			s e consequences a consequences										
Cause (Disease or injury that initieled events resulting in death) Lest Due to (or es a consequence of): d. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.									23b. Dtd tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4				se of death	
									24a. Was	an autopsy ormed?	ev co	ere autop allable pr mpletion death?		
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edical							26. Plec	e of Deet	h (Check only	one)		A A A A		
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ending evestigation	28e. Dete	ot Injury th, Day Year)	28	Bb. Time of Injury	M 28	lc. Inju Wo	ryet ork?]Yes 2.⊑	No	28d. Describe	how injury occu	rred			
could not be	≥59. Pieca	of Injury - At ng, etc. (Spe	t home	e, farm, stre	eet, factory,	office			28f. Location (City or To	Street and Num. wn, State)	ber or Rure	ai Route I	lumber,	
rtifying Phyr dtcat Exami	iner: On the ba	asis of exami	nowle	dge, deeth end/or Inv	occurred a	t the ti	ime, date a oplnion, de	nd place, eth occur	end due to the red at the time,	cause(s) and m date and place,	enner as s and due to	tated.	se(s)	
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	rtifying Phy dicat Exam	buildi rtifying Physician: To the dicat Examiner: On the buand manieriller	rtifying Physician: To the best of my k dicat Examiner: On the basis of exam and manner stated. artifler arson who completed cause of deeth (I	rtifying Physictan: To the best of my knowled dicat Examiner: On the basis of examinetion and manner stated. arising the completed cause of deeth (Item 2)	rtifying Physician: To the best of my knowledge, deet dicat Examiner: On the basis of examinetion end/or in and manner stated. artifler	rtifying Physictan: To the best of my knowledge, deeth occurred a dicat Examiner: On the basis of examinetion end/or investigation, and manner stated. 29c. arson who completed cause of deeth (Item 23e) (Type, Print)	riffying Physician: To the best of my knowledge, deeth occurred at the tidical Examiner: On the basis of examination and/or investigation, in my and manner stated. 29c. Licen D26 arson who completed cause of deeth (Item 23e) (Type, Print)	riffying Physician: To the best of my knowledge, deeth occurred at the time, date at dicat Examiner: On the basis of examination and/or investigation, in my opinion, default examiner stated. 29c. License number D26568 arson who completed cause of deeth (Item 23e) (Type, Print)	riffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, dicat Examiner: On the basis of examination and or investigation and or investigation and occurred at the time, date and place, dicat Examiner: On the basis of ex	letermined 256. Place of Injury - Artime, farm, street, factory, office 257. City or To building, etc. (Specify) riffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the dicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, and manner stated. 29c. License number D26568 arson who completed cause of deeth (Item 23e) (Type, Print)	rilfying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and m dicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and manner stated. 29c. License number D26568 AUGUST arson who-completed cause of deeth (Item 23e) (Type, Print)	riffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as a dicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to and manner stated. 29c. License number 29d. Date signed (Month, D26568 AUGUST 7, I arron who completed cause of deeth (Item 23e) (Type, Print)	ritifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. dicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause and manner stated. 29c. License number D26568 AUGUST 7, 1999 arson who completed cause of deeth (Item 23e) (Type, Print)	

32. Registrer's Signature

State Registrar 31. Dete filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death CATHERINE ROL AND August 11 1999 3:30 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's Hours Min. 8. Data of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Aga (In yrs. lest birthday) If Undar 1 Yaar 10 M 20 F Months Days 215-54-7269 Washington, DC Usual Residence of Deceden 10c City Town or Location 10b Counts 10d. Inside City Limits 1 ☐ Yes 2 No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11626 Kipling Drive 20601 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc 1 Nevar Marriad 2 Married Yes, Give 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede com Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Retail Carpet Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Lewis M. Jones Helen May Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert R. Roland/Husband 11626 Kipling Drive, Waldorf, Maryland 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State Forest Grove Cemetery 8-14-1999 LaPlata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furthral Service Lansee 22. Nama and Addrass of Facility The Huntt Funeral Home, Inc. 23a. Pant. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximately a provided the death. Approximately a provided the death. Approximately a provided the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximately a provided the death. Approximately a provided the dea Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): traci Irinary Due to (or as a consequence of) Iretera obstructio Due to (or as a consequenca of) olan cancer 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

pue

ettending physician

has

certificata

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific.

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

mew

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after o Inepartment of Health and Mental thygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumetic avent, the Medical Evantment once.

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner the burial-transit Physician/Medical signed by the et d be detached for py been si Completed funeral director, Be P Certification:

4 ☐ Homicide

29b. Signature and title of certified

25

29a. Certifier

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 DNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending Investigation 1 Watural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete)

State Registrar

Medical

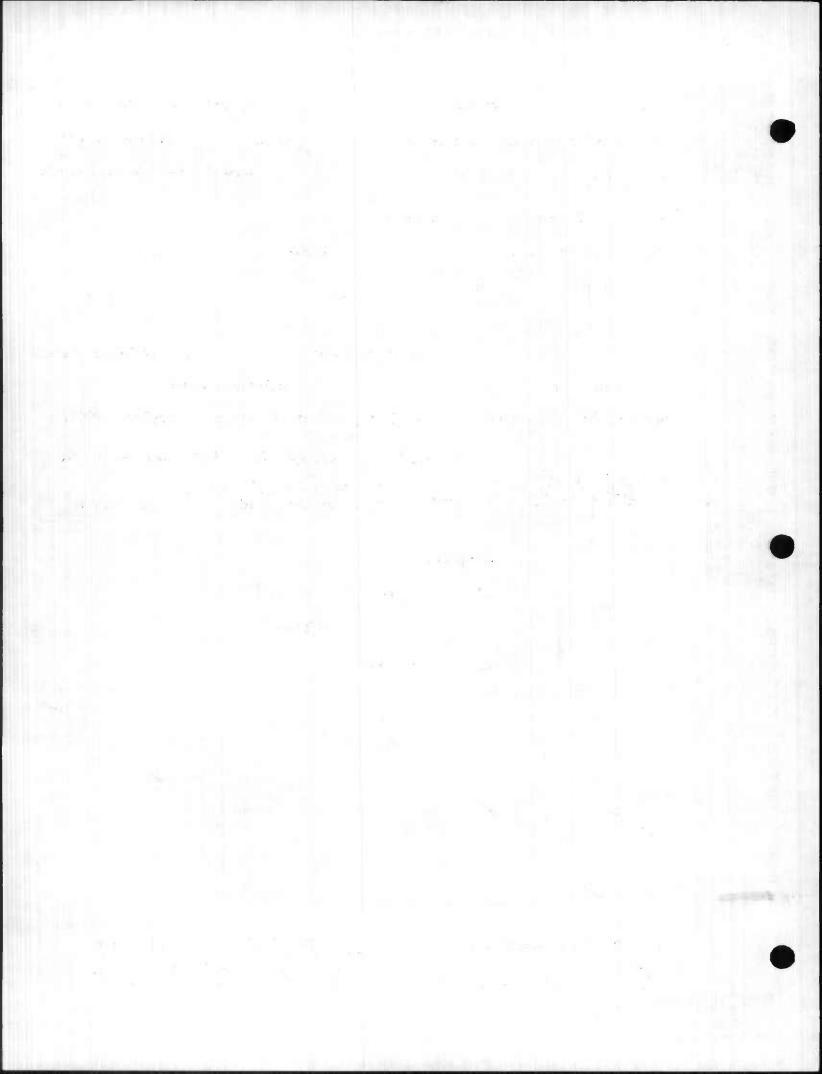
3 STRANTES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AR M 31. Pate filed (Month, Dey, Year) 32. Registrar's Signature AUG 1 3 1999

LUMICUL. MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Date signed (Month, Day, Year)

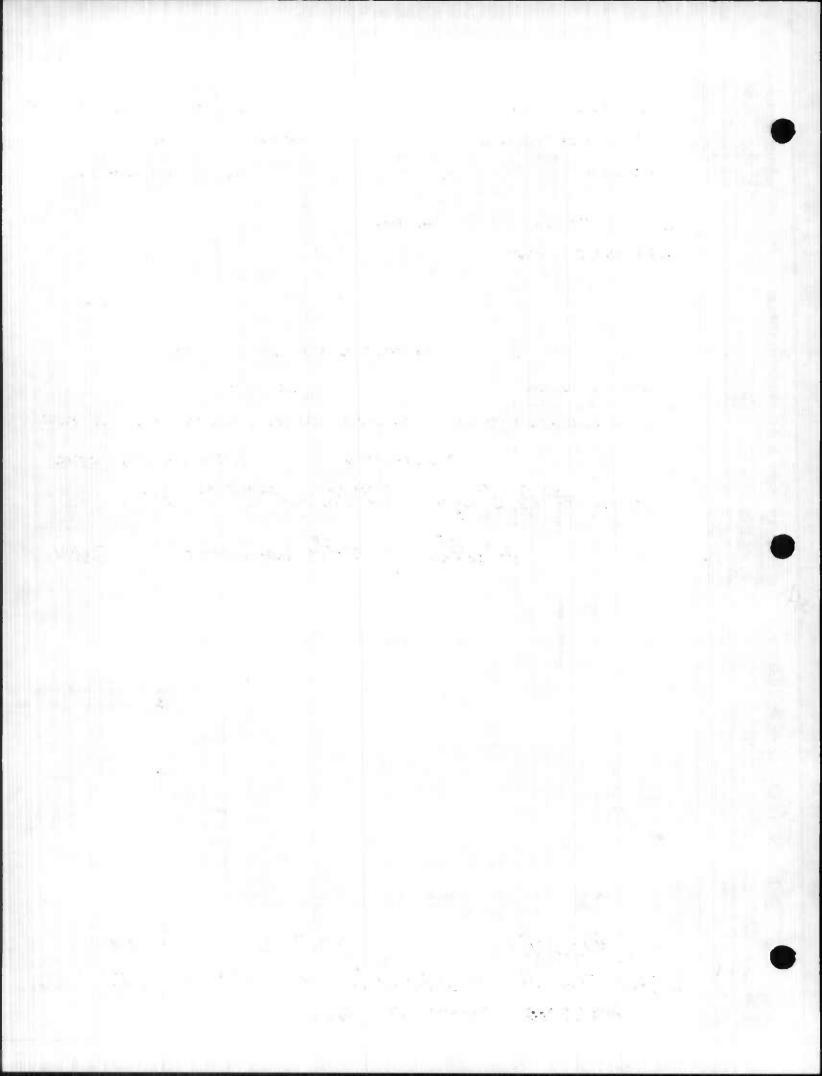


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State of Maryland / Department of Health and Mental Hygiene 9 9

26727

				Cer	tificate of	Death		Reg. No.			
lalan	1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month	eath Day	Year	3. Time of Death	
ysician Jedical	John William	Shores					Augus	t 11	1999	8:15 A.M	
aminer	4a Facility Name (If not institution						n, or Location of Dea		y of Death		
	714 Beards	Hill Road				Aberd		Har			
uneral Months Days							Hrs. 8. Date of Bi Min. (Month, D			place (Stete or Foreigntry)	
ctor	217–12–0901	TALWI ZUT	74	Yrs.			Mar. 3	, 1925	Mary]	Land	
a winn 72 hours enter oeath with the Meryland show. Then "natural", or hems 23s or 28s4 show the Medical Examiner must be notified at completed by Funeral Director.	Usual Residence of Decedent 10a. State 10b. County		1	0d. Inside City Limit							
		3	10c. City, 1							1 A Yes 2 □ N	
ect out	MD Harf	ora	AC	erdee	10f. Zip Code			10g Citizen of	What Cour	ntry?	
2 2	714 Beards Hil	1 Road			210	01		10g. Citizen of What Cour			
iner mult be notified Funeral Director	11. Marital Status	12, Was Decede	ent Ever in U.S.	13. \		* '	n? (Specify Yes or N		ce - Americ	can Indian,	
F. F.	1 Never Married 2 Marr	Armed Force	es?	1	Yes, specify Cul	ban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	Ble	ack, White,	etc.	
by	3 ☐ Widowed 4 ☐ Divorced	ied 1 1 Yes 2 If Yes, Give Year or Date	98:	1	Yes 2X No	Specify:		Speci	y: Whi	ite	
8	15. Decedent	's Education		16a. Deced	lent's Usual Occu	pation		16b. Kind of 8	Business/Inc	dustry	
Completed	(Specify only highest Elementary/Secondary (0-12)	st grade completed) College (1-4	or Eu)	(Give life. L	kind of work done OO NOT use retir	ed) during most o	of working				
Be Com	12	0	I	rive	r/Route	salesma	an	Diary			
BeC	17. Father's Name (First, Middle,	Last)		18. Mor			s Name (First, Middle	Meiden Sumame)			
0	William B. Sho	ores				Ella	Riley				
-	19a. informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Stree	et end Number	or Rural Route Num	ber, City or Town	n, Stete. Zip	Code)	
To	Margaret K. Sh	ores (Spou	ise)	714	Beards 1	Hill Ro	ad, Aberd	een, Mai	yland	21001	
	20a. Method of Disposition		20b. Plac	a of Dispo	sition (Neme of natory or other pl	ece)	Date	20c. Location	- City or To	own, State	
	1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		ate		etery		8/13/99	3/13/99 Aberdeen, Marylan			
	21. Signature of Funeral Service	Licensee			. Name and Add	ress of Facility		,			
	1/	201	2	I	arring-	Cargo F	uneral Ho	me, P.A.			
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	ised the death.	Do not ent	berdeen	ing, such as c	and ZIUU ardiac or respiratory	1-3399 arrest,		Approximate Interval Between	
Physician /Medical	shock, or heart failure. List	only one cause on eac	ch line.						į	Interval Between Onset and Death	
	Immediate Cause (Final	1401	The tree	- 1	10 MARES	Tue.	armon		-	7. ////	
	disease or condition resulting in death)	a. Wey	your	- 40		C	accepa	и	1	wy.	
ē			Due to (or a	s a corpor	luence or):				1		
Examiner	Sequentially list conditions	b	Due to (or a	s a consen	mence of).						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.										
edicai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or a	s a conseq	uenca of):				-		
Ped	resulting in death) Last								i		
an/M		d							I		
Sici	Part II. Other eignificant condition	ne contributing to deat	th but not resulti	ng in the u	nderlying cause g	iven in Part I.	23b. Did	I tobacco uea c	ontribute to	o the cause of deat	
Physician							1	Yee a No	3 Pro	bably 4 Unknow	
by 6							_	7			
								s an autopsy formed?	av	ere autopsy findings allable prior to	
pier							_		co	mpletion of cause death?	
Completed							1	Yes 20No	10	☐Yes 2☐No	
0	25. Was case referred to medical					26. Place	of Death (Check only				
OB	examiner?	Hospitel:	patient 2 EF	VOutpatien	t 3 DOA	ther:	10	idenca 6 🗆 O	ther (Specif	(y)	
Ë.	27. Manner of Death	28a. Date of		Bb. Time of	1		-	how injury occu			
atio	1 Natural 5 Pendin	9	Dey rear)	Injury		Yes 2 N	0				
il Ci	3 Sulcide 6 Could r		28f. Location (Street and Number or Rurel Route Number, City or Town, State)								
Certification:	4 Hornicide	building	, etc. (Specify)				City of Th	own, otato,			
ie		g Physician: To the be									
edicai	(Check only 2 Medical one)	Examiner: On the bas and manne		n and/or inv	restigation, in my	opinion, death	occurred at the time	, date and place	, and due to	o the cause(s)	
Σ	29b. Signature and title of curtille	X			29c. Licer	nse number		20d Date sign	ed (Month,	Day, Year)	
	1 Yack	u			DE	3171	2	8/12	199		
	30. Name and address of person	who completed cause	of death (Item 2	3a) (Type.	Print) A		1 1	-	-		
	CHAPLES ECX	- TIL 2	19 111.6	SIEL	HIR A	THE	ATBIET 4X	TEI), 1	MD	21001	
tate	31. Date tiled (Month, Day, Year)	32. Reg	istrar's Signatur	0			W	- V / _ V		[00]	
	AUG 1 2	1999	Special	13.	don	161					
rar											



10

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 1

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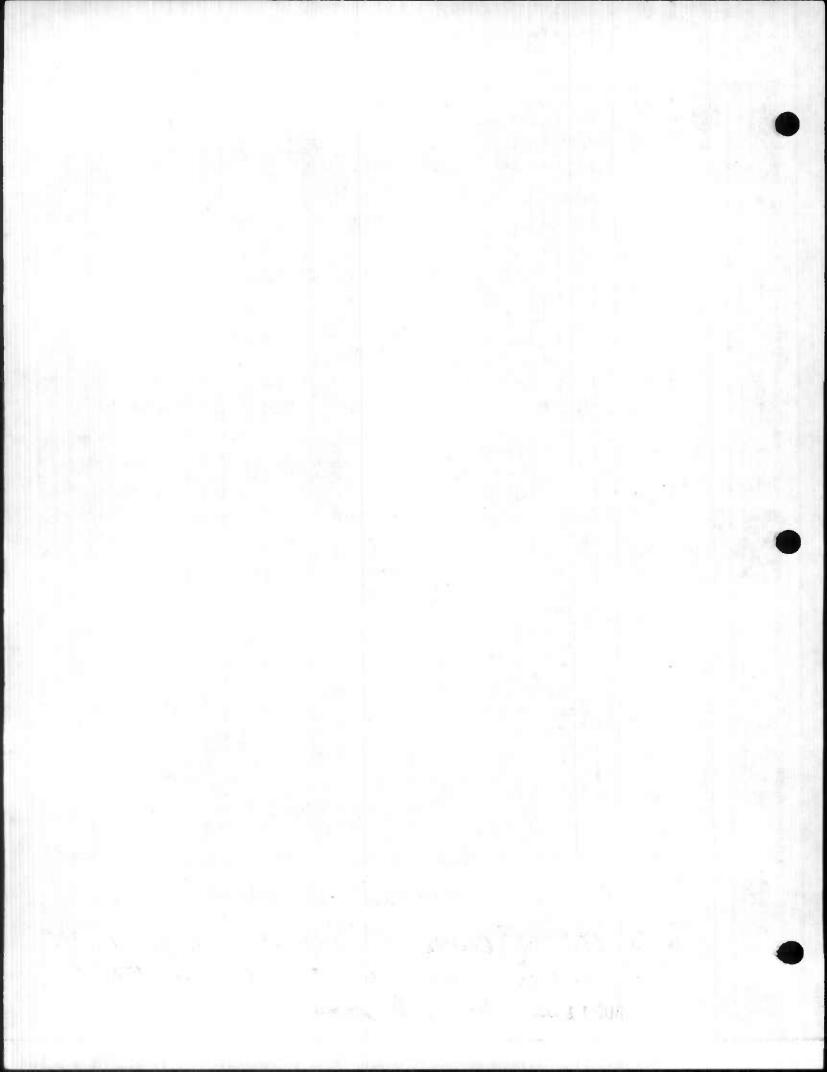
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print

B. Sporks

SCH

0 4981 August 7. 1989.

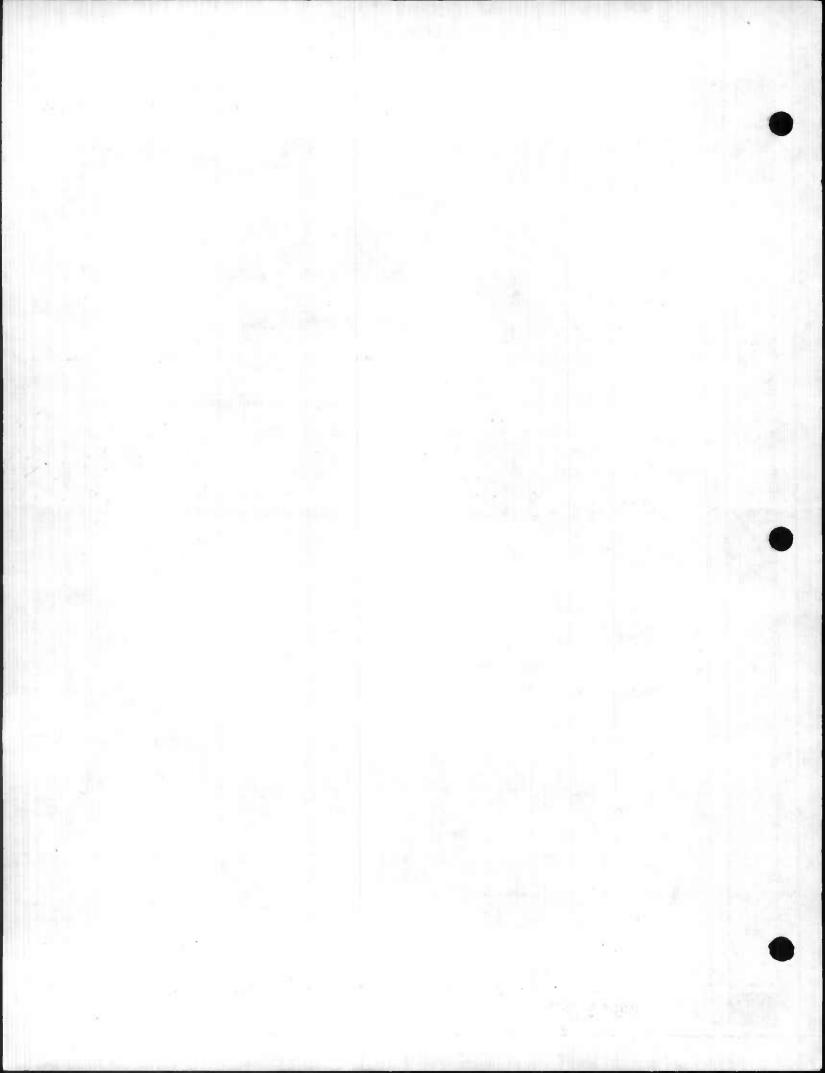
PLEX ST. CUMBERLAND. Md.



Please Type or Print in Biack indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

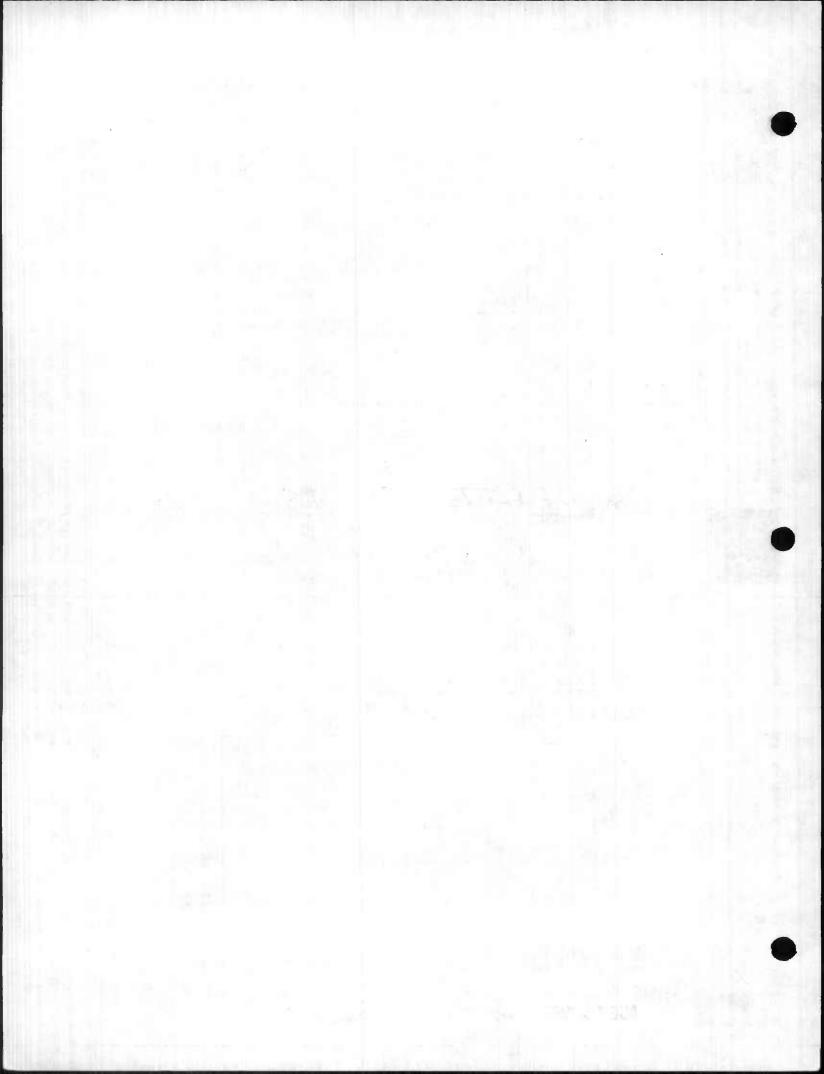
					Ce	rtifica	te of	Death			Reg.	No.	6	010	9
Dhusisian	1. Decedent's Name (F	irst, Middle, Las	ot)							2. Date of De Month		Day	Year	3. Time	of Death
nysician Medical	Philo	nena	Virgi	nia	Sma1	1			A	ugust				20	:55
aminer	4a Facility Neme (II not	institution, give	street end nur	nber)				4b. City, Tov	vn, or Lo	cation of Deat	h	4c. County	of Death		
	MEMORIAL H							CUMBER				ALLEGA			
	5. Social Security Numb 214-34-200	4 1	9X □ M 2\ \(\frac{1}{X}\)F	7. Age (In yrs. 87	last birthday Yrs.	Months	or 1 Yeer Days		Min.	8. Date of Bit 2 Month, D	91	2")	9. Birthi Coul	place (State	e or Foreign SA
	Usual Residence of Dec 10a. State 10	edent c. County		10c Cit	y, Town or L	ocation					_			IOd Ineida	City Limits
7	MD	Allega	27		stern										es 2 No
Director	10e. Street end Number		ily	WE	SLEIN		ip Code				100	Citizen of V	Mant Cour	41	
ral Dir			and Ave	nue		2	1562					US		nity r	
by Funeral	11. Meritel Stetus 1 ☐ Never Merried 3 ☑ Widowed 4 ☐	-	Armed For	1 ☐ Yes 2 ☑ No			edent of ecify Cut		jin? (Spe , Puerto F	cify Yes or No Rican, etc.))-		k, White,	can Indien etc. Vhite	
	15.	Decedent's Ed	ucation		16a. Dece	dent's Us	uel Occu	pation	of working	201	16t	. Kind of B	usiness/In	dustry	
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Be	17. Father's Name (Firs		lliam F	Rurns				18. Mother	r's Name	(First, Middle Elizab				,	
0				· Dullis						EIIZaL	ie L	11 0	Stude		
	19a. Intorment's Name									l Route Numb			State, Zip	Code)	
	James T.		JrSo					Wauk	tesha	-	-	187		-	
	20a. Method of Disposit 1 □ Burial 2 □ Ci 4 □ Donation 5 □	emation 3 🗆	Removel from (lace of Disp emetery, cre berlar	matory or	other pla	ory	8-1	Date 1-99		mb • MI			
	21. Signature of Funeral 23e. Pert1. Enter the d shock, or heart fei	Kul	lows	D	F	redlo	ck F		Hon	ne P.O.			Pied	lmont	
er	tmmediate Csuse (Fine disease or condition resulting in deeth)			RDIAL		TION								Onset at 4 day	nd Death
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury									1					
/Medical Examiner	Cause (Disease or Injur that initieted events resulting in death) Last	1	d	Due to (or es e consequence of):											48
101													1		
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacc									co use contributs to the cause of death					
by Ph	1 □ Yes 2 □ No 3										3 Pro	bably 4	Unknow		
Completed	24a. Was an autopsy performed?									8/	ere sutopo reilable pri ompletion of death?	orto			
Eo										10	Yes	2 No	1	☐Yes 2	□ No
BeC	25. Was case referred t	o medical						26. Place	of Death	(Check only					
To B	examiner?		Hospital:	npatient 2	ER/Outpatie	nt 3 D	OA O	hor		ne 5□Res		e 6 DOth	er (Sneci	%)	
	27. Manner of Death				28b. Time o					28d. Describe				97	-
catio	27. Manner of Death 1 Netural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work? 1 Nestigation 3 Sulcide 6 Could not be determined determined.									28f. Location	Street	at and Numb	ner or Rur	al Route N	lumher
Certification:	4 Homicide	determined	buildir	ng, etc. (Specif)	()					City or To	wn, S	itate)			
Medicai	29a. Certifier 1 2 0 0ne)	Certifying Phy Medical Exam	raician; To the inar; On the ba and mann	sis of examinal	wledge, deat tion end/or in	th occurred evestigation	d at the t n, in my	ime, date and opinion, deet	d place, a h occurre	and due to the ed et the time,	caus date	e(s) and ma and place,	anner as s and dua t	stated. o the caus	e(s)
M	29b. Signature end title	of certifier	1			29	9c. Licen	se number			29d.	Dete signe	d (Month,	Day, Yea	7)
	· M	larle	- D	ag			D.	354	81		ai	iqust	: Ilt	4,10	199
1	30. Name and address	ot parson who o	completed cause	e oldeath (Item	23a) (Type	Print)									
W,	Mark Sagin,	I.D. Me	emorial	Hosnit	al Sud	te 4	00 0	umber1	and	MD 21	50	2			
tate trar	31. Dete filed (Month, D	3 1999	38. R	oglstrar's Signa	ture G	100	de	/							



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Dev Year **Physician** Month LORETTA M. TIMBROOK AUGUST 1999 10:00PM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany Birthplece (State or Foreign Country) H Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) If Undar 24 Hrs 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months 1□M 2\ F Hours Yrs. 234-44-6938 69 Director March 7,1930 West Virginia Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside Cltv Limits 1 ☐ Yes 2 ☑ No Director 28a-f Mineral Keyser must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or flarms 23s or Rt. 1, Box 161-F 26726 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental is marked Victor C. Decker 2 Ruby M. Anderson 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Department of Health a Important: if Nem 27 is any Injury or other trau Vicki R. Klavuhn/Daughter Rt. 2, Box 219 Ridgeley, WV 26753 20b. Plece of Disposition (Neme of cematery, crematory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cramation 3 ☐ Removel from Stete Aug. 10 Biser Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 1999 Keyser, WV 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner Sequentielly list conditions, if any, leeding to immadieta cause. Enter Underlying Causa (Disease or Injury that initieted evants resulting in death) Last Due to (or es e consequence of) The law requires that the death certificate be execu Box 68760 Physician/Medical Dua to (or es a consequence of) P.O. I elgnificant conditions contributing to death but not resulting in the underlying causa givan in Pert t. 23b. Did tobecco use contribute to the cause of death? signed by i 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 s is certificate h director, page 1 Tyes 2 No 1 □ Yas 2 □ No Division of Vital Noapital or Attending Physician: 24 hours after death. Funeral Director: After this certifical 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 X Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation tnjury 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicide 28t. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide To the Nospital within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier 250. Signature and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) 10 m . P AUGUST M 30. Name and address of person wild o 23a) (Type, Print) umberland 32. Registrer's Signeture State AUG 1 2 1999 Registrar

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Day AUGUST 6, **Physician** 3:29 AM 1999 NELSON (NMI) THOMASSON III ' /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, give streat and number) Examiner **GARRETT** GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Social Security Number Birthplace (State or Foraign Country) **Funeral** Months Days 1 M 2 □ F 339-07-7109 Yrs. APRIL 24 1913 ILL 86 **Director** Usual Residence of Decedent with the Maryland 10a. Stata 10b. County SARASOTA 10c. City, Town or Location 10d. fosida City Limits SARASOTA ir than "natural", or items 23s or 28s-f show the Medical Examples must be notified at FL MT .- LAKE-PARK 1 X Yas 2 ☐ No GARRETT Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 34242 4420 OCEAN BOULEVARD 106-H-STREET 21550 USA permit. Pages 1 and 2 should be filed within 72 hours aftar death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a and injury or other traumatic event, the Medical Examiner manal once. Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: altimore, Maryland 21215-0020 Specify: WHITE by 3 N Widowad 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Collega (1-4or 5+) Elementery/Secondery (0-12) EXECUTIVE PAPER COMPANY 18. Mother's Nema (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) GARDINER NELSON THOMASSON, JR. INDIE 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) ALEXANDRIA, VA 22314 INDIE G. CATHER - DAUGHTER 421 WILKES ST. 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State OMEGA CREMATORY 8/7/99 MORGANTOWN, WV 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete fntarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In deeth) /Medical CARDIOPULMONARY ARREST **Examiner** Dua to (or as a consequence of): Examiner UNCONTROLLABLE HYPERTENSION physician and the buriel-transit Sequantially list conditions, if any, laeding to Immediata causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): RECENT MAJOR ABDOMINAL SURGERY P.O. Box 68760. certificate be Physician/Medical Dua to (or as a consequance of): 89 950 for 23b. Did tobacco use contribute to the cause of death? Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yee 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? paga 2 certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminar? director 26. Placa of Deeth (Check only ona) Be Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 10 this 28a. Data of Injury (Month, Dey Year) funeral 27. Mennar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: 1 X Natural 5 Panding 1 TYes 2 No death. invastigation 2 Accidant after death Director: 6 Could not be datamined 3 Sulcida 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

State Registrar

3

Medical

4 ☐ Homicida

(Check only one)

29b. Signature apartif

IHOL

30. Nama and address of person wh

29a. Cartifian

24 hours after Funeret Direct bletaly filled in b

To the Hosp within 24 hor To the Fune completely fi

Hospitai

32. Registrar's Signatura AUG

and mannar stated.

ZAKALURNT

o complated cause of death (Itam 23a) (Type, Print)

Suirs 1

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end mennar as etated.

29c. License number

er: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s)

301 NORTH

29d. Data signed (Month, Pay, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** ROBTSON TODD August NATALIE 0800 /Medical 4b. City, Town, or Location of Beath 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Cambridge Dorchester Chesapeake Woods Center If Under 1 Year 5. Social Sacurity Number if Under 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 10 1912 Birthpleca (State or Foreign Country) Days 1 M 2 Months Hours 87 214-07-7359 Pennsylvania Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cambridge Ter 2 No MD Dorchester Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Coda 21613 525 Glenburn Ave. Funerai 12. Was Decedent Evar in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Nevar Married 2 Marriad 1 Yas 25 No Specify: à Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) receptionist medical 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be ROBISON Gerlach Rov Hazel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13641 Ambassador Drive, Germantown, MD 20874 Ms. Mary Ann Todd-daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 8-14-99 Salisbury Crematory Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Thomas Funeral Home, PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aech line. Immediate Cause (Final disaase or condition resulting in death) Due to (or es e consequenca of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No. 3 Probably 4 Unknown LOPPA Ď 24b. Were autopsy findings availabla prior to completion of cause of daath? 24a. Was an eutopsy performad? Completed 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) To 1 Yes 3€ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

physician and the burief-transit P.O. Box 68760 signed by the at d be detached for Records, peed Division of Vital after deeth.

Director: After this certific funeral 24 hours a Funeral D To the Hosp within 24 ho To the Fune completely f

Funeral

Director

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Heeth and Mantal Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartified

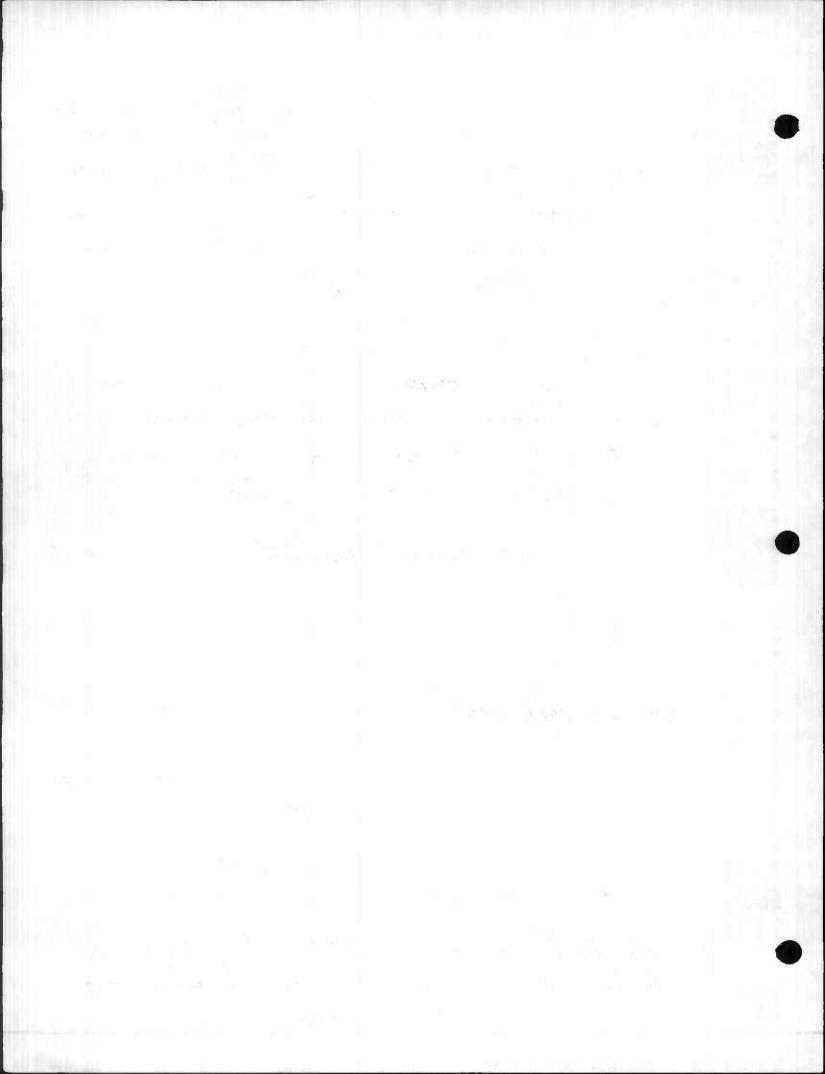
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) collins

Registrar

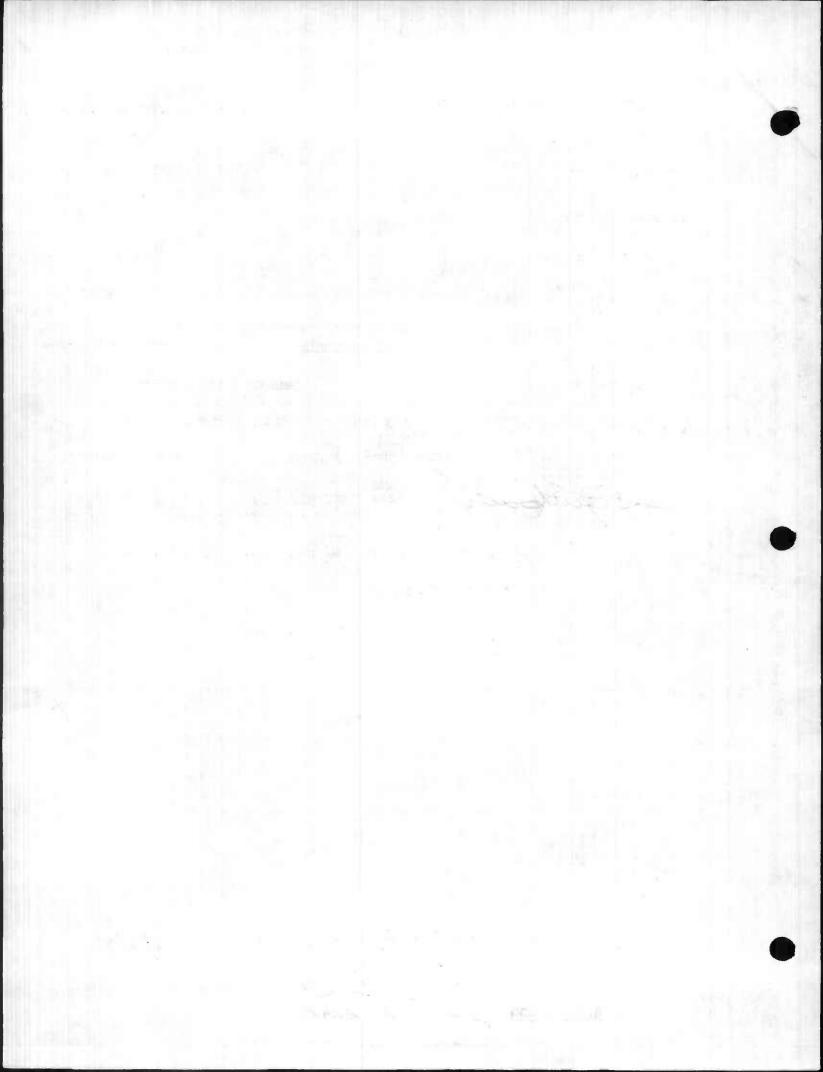
Medical





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		State o	f Maryla	nd / Department	of Health and	d Mental Hygiene	26
5, 18	PER	MEO	G775	² Certificate	of Death	Reg. No.	(L. V
ne (First, Middle						2. Date of Death	

AMEND	ITEMS: #5, 18 PER MEO G775 To be denoted by the state of Maryland / Department of Health at 1. Decedent's Name (First, Middle, Last)						
Physician		Month Day Year					
/Medical	to Equiliar Name (Mant institution the street and combat)	n, or Location of Death 4c. County of Death					
Examiner	BERLIN NURSING HOME BERL						
Funeral Director	5. Social Security Number 17. Age (In yrs. last birthday) 1 Under 1 Year II Under 2. 17. 3-3-3-37.17 6. Sex 12. IX. M 2 F 86 Yrs. Months Days Hours						
2 .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. fnside City Limits					
with the Marylar a or 28e4 show be notified at Director		1X Yes 2 □ No					
vith the Ma l or 28a-f s be notified	10e. Sfreef and Number 10f. Zip Code	10g. Citizen of What Country?					
23a o unt be		U.S.A.					
020 ors after des ef, or items Examiner in	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 1 Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, specify Cuban, Mexican, 1 Yes 2 No If Yes, Give Year or Deates:	in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE					
1 21215-0020 ed within 72 hours at ygains "rathurs", or it, the Medical Exam Completed by 1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) TRUCK DRIVER	of working 16b. Kind of Business/Industry HIGHWAY DEPARTMENT					
		's Name (First, Middle, Maiden Sumame)					
Maryland 12 should be tile 14 and Mental Hy 7 le merked othe traumette event	JOHN TAYLOR JANI	E CAMPBELL MCGULL MUNGALL					
any show	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)					
- C. C. C. C.	PATRICIA ANN STEINBRICK 423 PROVIDENCE PI	KE, PUTNAM, CT 06260					
Papes 1. Papes 1. mart of He ant: If Hen jury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) EASTERN SHORE CREMATORT	Date 20c. Location - City or Town, State LEWES, DELAWARE					
Balti permit. Departm importar any inju		HOMES & CREMATORIUM AY, LEWES, DE 19958					
ficate be executed Examiner street burist-transit edical Examiner		SCULLAR DISENSE					
0 = - 0							
Beath death death dior differ	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?					
P.O. d by the detacher		1 Yes 2 No 3 Probably 4 SUnknown					
() - 400 =		24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
		1 ☐ Yes 🛣 No 1 ☐ Yes 🛣 No					
Vital Interest The certificate irector, pag	25. Was case referred to medical avantiper?	of Death (Check only one)					
To still by	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs	sing Home 5 Residence 8 Other (Specify)					
C & 5 6 0	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 3 Suicide 8 Could not be 3. Suicide 8 Could not be						
DIVI Hospital or Att Runeral Direct stely filled in by silical Certifi	4 Homicide determined determined building, etc. (Specify)	y, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
\$ 5 5 d	IX Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 ☐ Medical Examiner. On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time, date and place, and due to the cause(s)					
or property of the property of	29b. Signature and tale of certifier EDWIN CASTANEDA M.D. 29c. License number 04625	29d. Date signed (Month, Day, Year) 8/14/25					
	30. Name and eddress of person who completed cause of death (Item 23a) (Type Print) G114 Healfleway Price (Beclein M)	21811					
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 5 1999 Apouls						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 15, per F.D. 8/10/99, Carroll County, wjl Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** 9, LAWRENCE WILKES WEBSTER AUGUST 1999 6:10AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 62 B SOUTH COLONIAL AVENUE WESTMINSTER CARROLL If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Months 579-40-9379 Yrs. 68 **Director** AUG. 8, 1931 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f shorthe Wedical Examiner must be notified at 1 ¥ Yes 2 □ No MD CARROLL Directo WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 62 B SOUTH COLONIAL AVENUE 21157 UNITED STATES Funerai death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1951-53 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: by WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHIEF MEDICAL TECH. HEALTH CARE 16 4 other 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Name (First, Middle, Last) Be Is marked of Pages 1 and 2 should be LAWRENCE WEBSTER DOROTHY CARTWRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 BOXWOOD AVE.WESTMINSTER, MD 21157 Department of Health Important: If Nem 27 M. LYNN EARP/DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State CARROLL CREMATORY 8/13/99 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157 or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. Approximate Intervai Between Onset and Death **Physician** /Medical immediate Cause (Final 640BLASTOMA disease or condition resulting in death) **Examiner** Examiner certificate be executed sician and burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 physician Physician/Medical the Due to (or as a consequence of): use as P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Completed peen performed? page 2 1 Tyes 2 No 1 Yes 2 No certificate Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: ii or Attending P s after death. ii Director: After i 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

218 Washington Keight Ked Ctn. Westminster to 2/157

29d. Date signed (Month, Day, Year)

To the Hosp within 24 ho To the Fune completely fi

Hospital 24 hours

> State Registrar

edical

29a. Certifier

(Check only one)

orman 31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

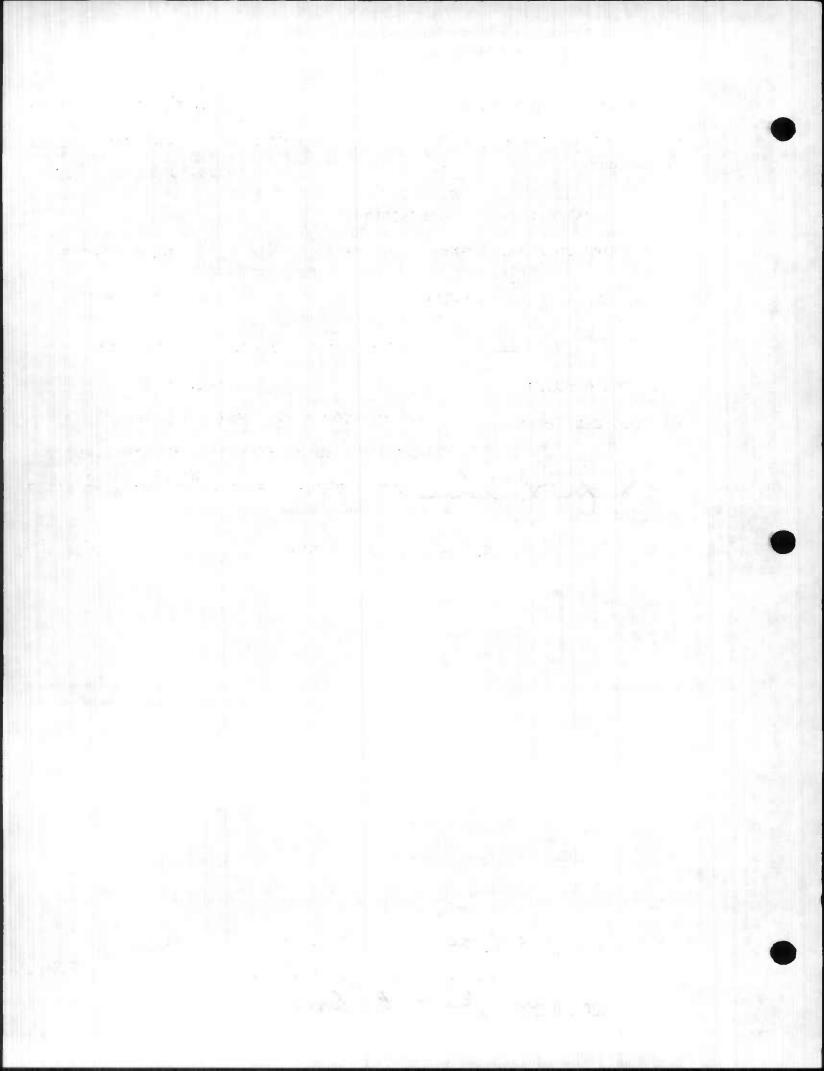
norman

AUG 10

Galdstein

30. Name and eddress of person who completed ceuse of death (item 23a) (Type, Print)

32. Registar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** Homer В. Warehime Aug. 10 1999 1:55 am /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Carroll 38 West George STreet Westminster If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1 € M 2 □ F Months Yrs. 219-14-8645 76 **Director** Apr 10 1928 Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Carroll Westminster Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with Street 38 West George 21157 USA Funerai 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3€Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) other than 12 Sign Manufacturer 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H is marked ou Bertha Brown Norman Warehime 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Peges 1 end 2 sinent of Heelth an POB 2210 Westminster, MD 21157 James P. Warehime/son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete permit. Peges Department of Important: If it any injury or o XBuriel 2 Cremetion 3 Removel from State 8/12/99 Westminster, 4 ☐ Donetion 5 ☐ Other (Specify) Meadow Branch Cem 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee Pritts Funeral Home & Chapel 412 Washington Rd. Westminster, MD 21157 23a. Pert 1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel laurces disease or condition resulting in death) Examiner Examiner ician end burial-transit the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physiclan/Medical Due to (or as a consequence of) ed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions, contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed by that þ requires 24b. Were eutopsy findings evaileble prior to Completed 24a. Wes en autopsy performed? peed completion of ceuse of deeth? a× this certificate has The 1 Yes 2 No 1 ☐ Yes 2 No of Vital Physician: director, 25. Wes cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes funaral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of After 5 Pending investigation Attending 1 Naturel val or Ah.

vurs after dea.

vi Director: Ah.

in by the fur-1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b. 🛣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner es stated 29a. Certifie edical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner steted. (Check only one) 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signati eddress of person who completed cause of deeth (Item 23a) (Type, Print) 30. Neme and 21157

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 1 1999

32. Registrer's Signature

Deper

1025 11 1 25 2 1 1 2 1 2 1 2 1 Year in State of the State andreas from the Br

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Aug 5, 1999 Keith Ray Wheeler 0050 /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Garrett Oakland Garrett Co. Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 2 1921 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 X M 2 D F Months Deys Hours Min. Yrs. 176 12 6167 78 **Director** Pa Usuel Residence of Deceden with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Kitzmiller, Md Md Garrett 1 ☐ Yes 2 ☑ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 Vindex Rd 21538 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marltel Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give WWII Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 Specify White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Eiementery/Secondery (0-12) College (1-4or 5+) 12 Patapsco & Backriver R.R. Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Raymond Wheeler Edna Mayhorn 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Wheeler 100 Vindex Rd. Kitzmiller, Md 21538 other 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State Cumberland Crematory

Cumberland Crematory permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State Aug 6 99 Cumberland Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee David A. Burdock FH 710 Church St. Kitzmiller,Md 23a. P-rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest hock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical immediate acute myocardial infarction Examiner Due to (or es e consequenca of): Examiner atherosclerotic heart disease years certificate be executed ician and burial-trans Sequentielly list conditions, it eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in death) Lest Due to (or es e consequence of): diabetes mellitus vears physician Physician/Medicai the Due to (or as e consequence of): 88 USB ō 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the th 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were eutopsy findings available prior to 24e. Wes an autopsy performed? Completed completion of cause of death? page 2 s certificate hes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth

Box 68760 P.0. Records, Division of Vital this funerai After

Certification:

edicai

1. Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of dertified

or Attending 24 hours after death. Hospital To the within 2 To the

D15333

🗠 Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated

2 Medical Examiner: On the basis of examinetion end/or investigation, in my optnion, deeth occurred at the time, date and pleca, end dua to the cause(s) end menner steted.

29c. License number

28c. Injury et Work?

1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

21550 Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

State Registrar

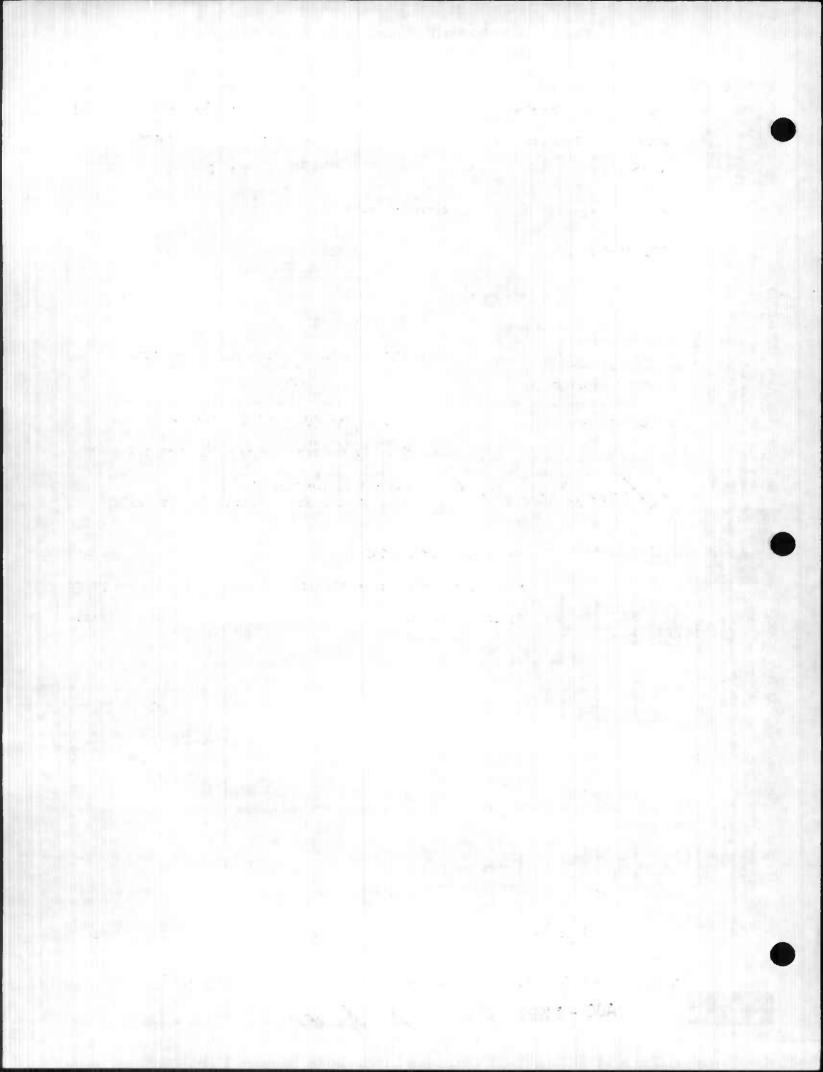
31. Dete filed (Month, Dey, Yeer) AUG - 6 1999

5 Pending Investigation

6 Could not be determined



D. Sports



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Marvin Paul Warnick 3 1999 1:50 AM August 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospital If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sax 1 M 2 ☐ F 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Hours Months Days Min Yrs 220-16-5834 75 June 14, 1924 Maryland Usual Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Laytonsville Montgomery 1 Yas 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4911 Sundown Road 20882 USA 12. Was Dacadant Evar In U,S. Armed Forcas? 1 X Yas 2 ☐ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Mantal Status Black, Whita, atc. 1 ☐ Navar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowad 4 Divorced Yaaror Datas: WW II 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) Collega (1-4or 5+) Revenue Officer Internal Revenue Serv. 12 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) William Clay Warnick Julia Ellen Lee 19b. Meiling Address (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) 19e. Informant's Name/Ralationship (Type, Print) Freda W. Warnick/Wife 4911 Sundown Rd., Laytonsville, MD 20b. Plece of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Bittinger Cemetery, Aug. 6, 1999 Bittinger, MD 22. Nama and Addrass of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 179 Miller St., PO Box 275, Grantsville, MD 21536 ntar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, then the disease, or complications that caused the death. Approximate Interval Batween Onset and Death Immediata Causa (Final disaasa or conditior rasulting in daath) Dua to (or as a consequence of): Dua to (or as a consequanca of):

Physician /Medical Examiner

that the daath cartificate be executed

Division of Vital Records, P.O. Box 68760,

Department of Important: If any Injury or

Physician

Examiner

Funeral

Director

ne 23a or 28a-f show

"natural", or items evical Examiner m

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itellury or other traumatic event, its Menical Examines

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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/Medical

10a. Stata

MD

Examiner Physician/Medical à Completed Be 10

physician and the bunat-transit SS eşn Por ed by the a signed by page 2 director, funeral Certification:

certificate

After this

aftar death. Director: Aft

24 hours a Hospital

To the Hosp within 24 ho To the Fune completely fi

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or Attending Physician:

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that Initiated evants rasulting in daath) Last

Part II. Other algnificant conditions contributing to death bot not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en autopsy

24b. Ware autopsy findings available prior to complation of cause of death?

2 No 1 Yas

1 ☐ Yas 2 ☐ No

25. Was casa refarred to medical axaminar? 1 Yas 2 No 27. Mepher of Death

1 Natural

2 Accident

3 Suicida

29a. Certifier

4 Homicida

5 ☐ Panding invastigation

Hospital:

1 Thpatiant 28a. Data of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Tima of

28c. Injury at Work? 1 Yas 2 No 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

26. Placa of Death (Check only ona)

Medicul Center

Othar: 4 ☐ Nursing Homa 5 ☐ Residanca 6 ☐ Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the beat of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

(Check only one) 29b. Signeture and titla

29c. Licansa number

29d. Data signed (Month, Day, Year)

6 Could not be datamined

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) MICHAEL

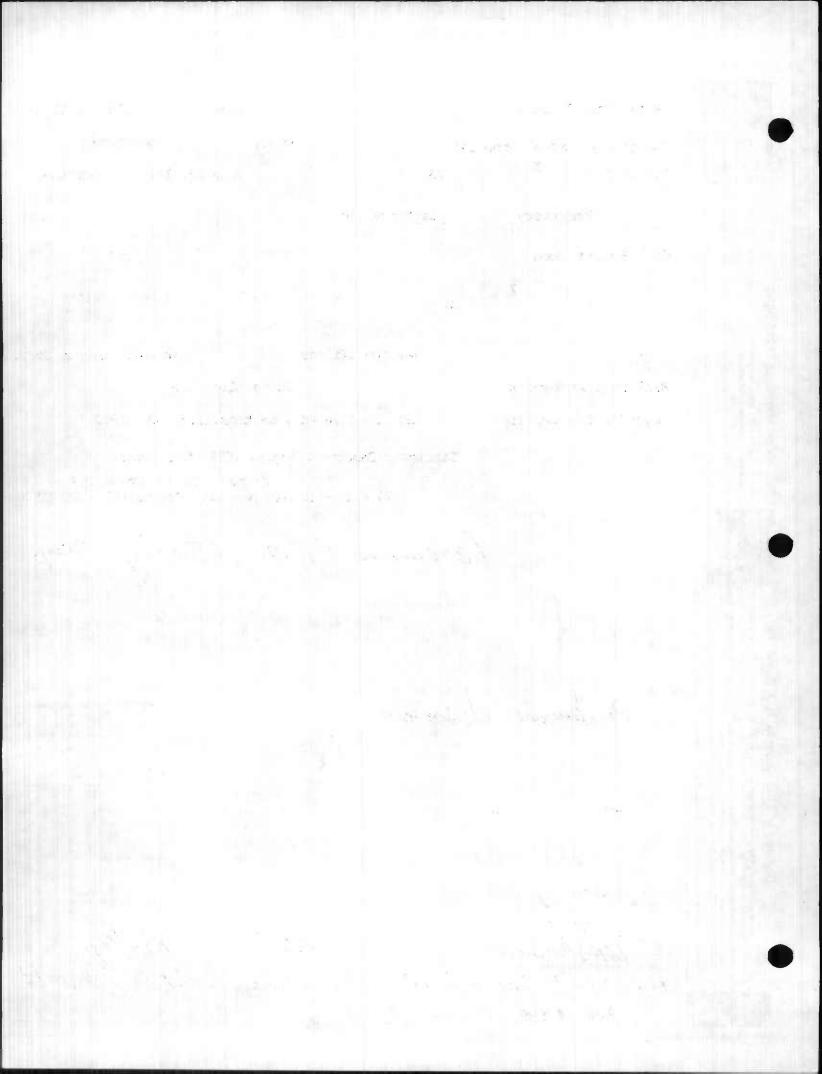
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32. Registrar's Signatura

DULKIL

AUG 6 1999

DHMH 16 Ray 6/95



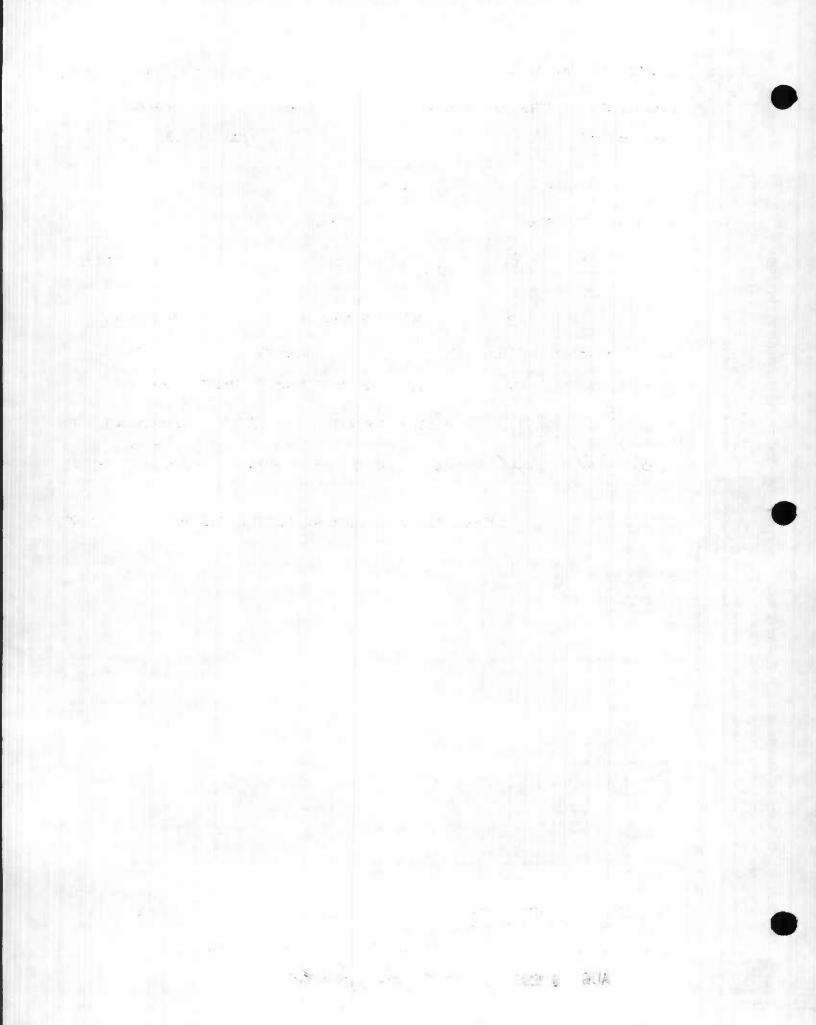
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State of Maryland / Department of Health and Mental Hygier 9

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							C	Certifica	te of	Death		R	eg. No.			
			1. Decedent's Name (First, Middle,									2. Dete of Deel Month	th Day	Year	3. Time	of Death
н	Physicia /Medic	_	EDWARD GILBERT	T WETZE	L, 3	JR.						AUGUST	5, 19		11:3	39 P.M
	Examin		4a Facility Name (If not institution, GARRETT COUNTY		11-1-1	SPIT	AL				wn, or Lo	ocation of Death	4c. Coun	ity of Death		
	Funeral Director		5. Social Security Number 187–20–0189	6. Sex 1 ∑ M 2□ F		(In yrs. I 72	ast birtho	Months	Day:		24 Hrs. Min.	8. Date of Birth Month, Pay MAY 28,	1927	9. Birthp Cour PA	olace (State	e or Foreign
	Du ,		Usual Residance of Decedent			10- 07	-									m: 11 t
	the Marylen 28a-f ehow	ctor	MD GARRE	ETT		TUC. City		NTON								City Limits
	23a or 24	Funeral Director	10e. Street end Number 538 YACHT CLUB	ROAD				10f. Z	ip Code 2156	51		1	10g. Citizen of What Country USA			
020	ours after dee	ρ	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced		Forces? s 2 ☐ No Give			13. Was Dec If Yes, sp 1 Yes	ecify Cu	ban, Mexicar	gln? (Spo n, Puerto	Specify Yes or No- nto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHITE		
5-0	noturel',	eted	15. Decedent's (Specify only highest	s Education	d)		16a. D	ecedent's Us	ual Occi	upation e dunng mos	t of work	ina	16b. Kind of	Buainess/in	duatry	
21215-0020	within ene.	Completed	Elemantary/Secondary (0-12)		(1-4or 5+)	11	INESS	use retii	(ed)			LUMBER YARD			
pu	be filed d other event,	Be	17. Father'a Name (First, Middle, L	ast)						18. Mothe	er's Name	e (First, Middle, I	Maiden Sum	ame)		
Na Na		9	EDWARD GILBERT	C WETZE	L, S	SR.				HE	LEN]	PARKEF	}	
, Maryland	Pages 1 end 2 s nent of Health ar int: If flem 27 ie irry or other treu		19a. informant's Name/Relationsh ELLEN F. WETZEI									SWANTON			Code)	
altimore,			ELLEN F. WETZEL - WIFE 20a. Method of Disposition 1								8	Deta /6/99	20c. Location MORGA			
Balt	permit. Pag Department important: I any injury o once.		21. Signature 6 Funeral Service Licenses MO0167 MO0167 DURST FUNERAL HOME - OAKLAND, M												1550	
	31.15		23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that	it caused the	he death	. Do no	enter the mo	de of d	ring, such as	cardiac	or respiratory arr	est,	1	Approxim	Batween
	Physician /Medical Examiner		immediate Cause (Final disease or condition resulting in death)	aA		444	-	TIC CC		ARY VA	SCUL	AR DISE	ASE	1	Onset an	
	uted d ansit	Examiner	b													
68760,	ficete be execute physician and st the burial-trans		Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	c										1		
×	ding	//Medical	resulting in death) Last	d	D	ue to (or	es e cor	isequence of	:							
80	death of ettern	clar	Part II. Other significant condition	e contributing to	donth but	not recu	lting in t	ne underlying	cauce (iven in Part I		23b Did to	obacco use	contribute t	o the ceus	e of death?
P.0	es that the de igned by the e i be detached i	y Physician	Tajin. Otro algimouni condito	to continuoung to	dodin but	110(1650	iting it t	io dildollynig	02030	JAVOIT WITT OIL			'es 2□ No			X Unknown
Records,	e law requires that the has been signed by th ge 2 should be detach	Completed by							ī			24e. Was e perfor		av cc	ere autopo vailable pri ompletion of death?	
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Vital	ilcian: Th certificate rector, par	Be	25. Was case referred to medical examiner?								a of Deat	h (Check only or	na)			
0	F 10 T1	9	1X Yas 2□ No		☐ Inpatient		ER/Outp		AUA		ursing Ho	ome 5 Resid			(ty)	
	Attending P or death. ector: After by the funera	ation:	27. Mannar of Daath 1 🛣 Natural 5 🗆 Pending 2 🗆 Accident Investige	ation (M	te of Injury onth, Day		28b. Tin Inju		28c. In W	uryat ork? ⊒Yes 2 □	No	28d. Describe h	ow Injury occ	curred		
Division	al or Attend s after death il Director: /	Certification:	3 Sulcide 6 Could no datermin	ned 288. Pla	ice of Injur ilding, etc.	y - At ho (Specify	me, fam	a, atreet, facto	ry, offic	8		28f. Location (S City or Tow		m <i>ber or R</i> ur	al Route N	lum <i>ber,</i>
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	within To th	ž	29b. Signeture end title of certifier	0				2	9c. Lice	nse number		2	29d. Dete sig	ned (Month,	Day, Year	r)
)			30. Name and address of person w	to completed as	O _c	atil Hom	23a) (T	/pe. Print)	Н2	6154			AUGUS	T 5,	1999	
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	Stat	e	31. Date filed (Month, Day, Year)	32	. Registrar	's Signal	ure	6	1							

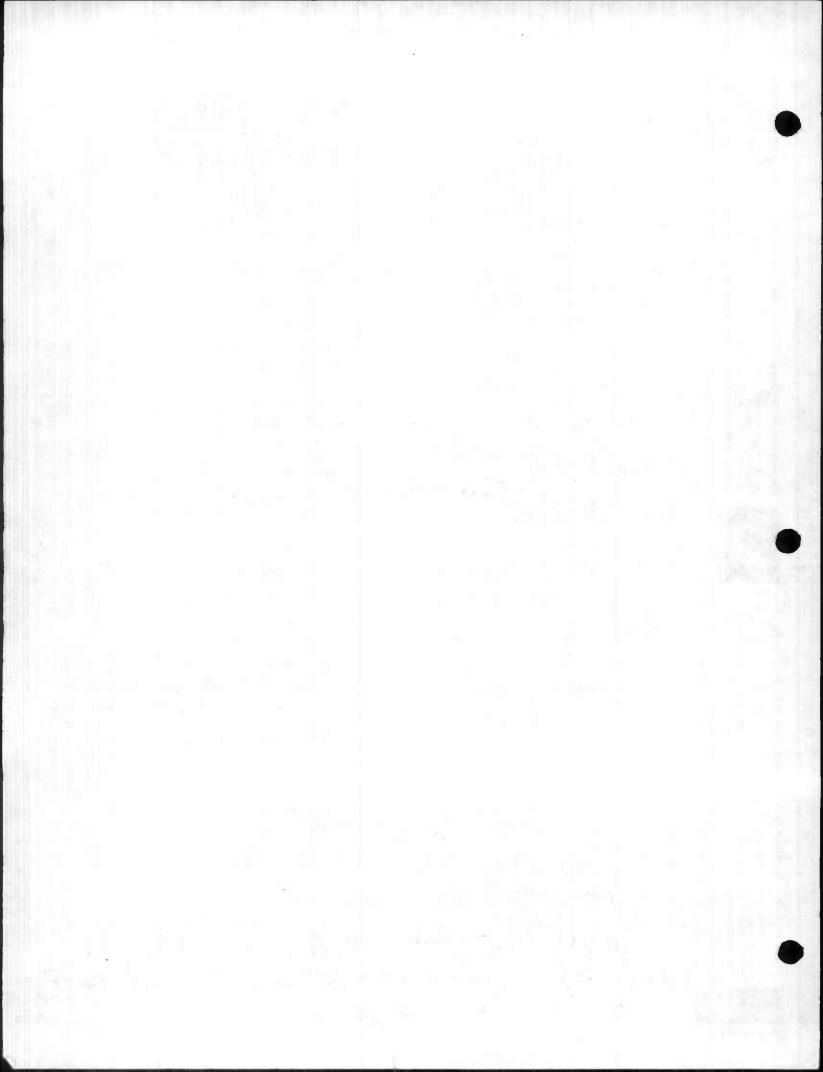
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State of Maryland / Department of Health and Mental Hygiene 99

						Cen	tificate of	Death		Reg. No.	67				
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	Exami		4e. Facility Neme (If not institution, gi	ve straat and numbe	r)			4b. City, Town, or	Location of Deeth			o v r r d iii			
			CIVISTA Med	ical Ce	enter			LaPla	ta	Cha	rles				
	, Funeral Director		213-38-6227	Sex 7. A 1 M 2 F 60	Age (In yrs. lest b	Yrs.	Months Deys	If Under 24 Hrs Hours Min	s. 8. Dete of Bird (Month, De February	h y, Year) 7 15,39	9. Birthp Cour Mary.	liace (State or Foreign ifry) Land			
	and w		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	wn or Loc	ation				1	Od Ineida City Limite			
	faryl sho	6			Wald										
	28e	Director	Maryland Charle 10e. Street end Number	25	Wait	OLI	10f. Zip Code			10g. Citizan ot 1	What Cour	atn/2			
	Juithin 72 hours after death with the Maryland jiena. r than "natural", or ferma 23e or 28a-f show the Modical Examiner must be notified at	Funeral Di	15096 Hoffman Rd	I do Miss Bassels	A. Francis 11 0	10.11	20601			U.S.A	A.				
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21215-0020	urai, or	by	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☐ It Yes, Give Yeer or Detes	-	11	☐ Yes 2☐ No	Specify:		Specif	Bla	ack			
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altimore,	Se lo L		20e. Method of Disposition 1 Regurial 2 Cremetion 3 Remove from Stete 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) St. Marys Cath. Ch Aug. 14,99												
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			23a. Part1. Enter the disease, or com	pilcations that cause	ed the death Do										
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9	/Medical		Immediete Ceuse (Finel	Act	10,000							70.1			
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0	y th	Physician/	Total aignituant outlanding	ontributing to death	but not resulting	an the und	enying cause gi	ven in Fenti.	1 0			8:11am ath S Inthpiace (State or Foreign Foundly) Syland 10d. Inside City Limits Yas 2 No Sountry? Serican Indien, ite, etc. Black Sindustry G OF Education Town, Stete Maryland Approximate Intervel Between Onsat and Deeth Onsat and Deeth 28 Y Were eutopsy tindings available prior to completion of cause of deeth? 1 Yes 2 No Socify) Sural Route Number, Stated.			
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 150 Certifying Ph	ysician: To the best	ot my knowledo	e death o	coursed at the ti	me date and place	and due to the	anuac(c) and ma	nner on et	atad			
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	within To the comple	Me	29b. Signature and title of bertifier	1 .	. 44 *	_	29c. Licens	se number		29d. Date signe	d (Month. I	Dav. Year)			
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			Angela Fayler	Bown N	deeth (Item 23a)	(Type, Pr	u MDOS	ISGUEP.	1043 Bos	ton St (Andi	reus AFB M			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 9ugust pm 24 /Medical EUGENE BUTLER 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner General laryland Hospital Baltimore 5. Social Security Number If Undar 24 Hrs. 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 218-05-0599 Yrs 85 Director 08/14/1914 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA Funeral 110 W. 20TH STREET . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK þ 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARRY BUTLER MARY CROSBY 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE LANDON/NIECE 1423 WISP CT. HANOVER, MD. Date 21076 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XBurial 2 Cremation 3 Ramoval from State ZION MT 8 30 99 4 ☐ Donation 5 ☐ Other (Specify) JAMES A. MORTON& 21. Signature of Funeral Service Licansee SONS F.H., INC W a. 1701 LAURENS ST. BALTO., MD. 21217 mm. Ther tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate tntervel Between Onset and Death /Medical Immediete Cause (Fina! disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical that initiated events rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of causa of death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to tha cause(s) and manner as stated. edical 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one)

Box 68760 P.O. Division of Vital Records. To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: After

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ed other than "natural", or hams 23s or event, the Medical Examiner must be r

Maryland 21215-0020

Baltimore,

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Pages ment of h important: If its any injury

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Registrar

31. Dete tiled (Month, Day, Year)

29b. Signature and title of certifier

Chandok

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

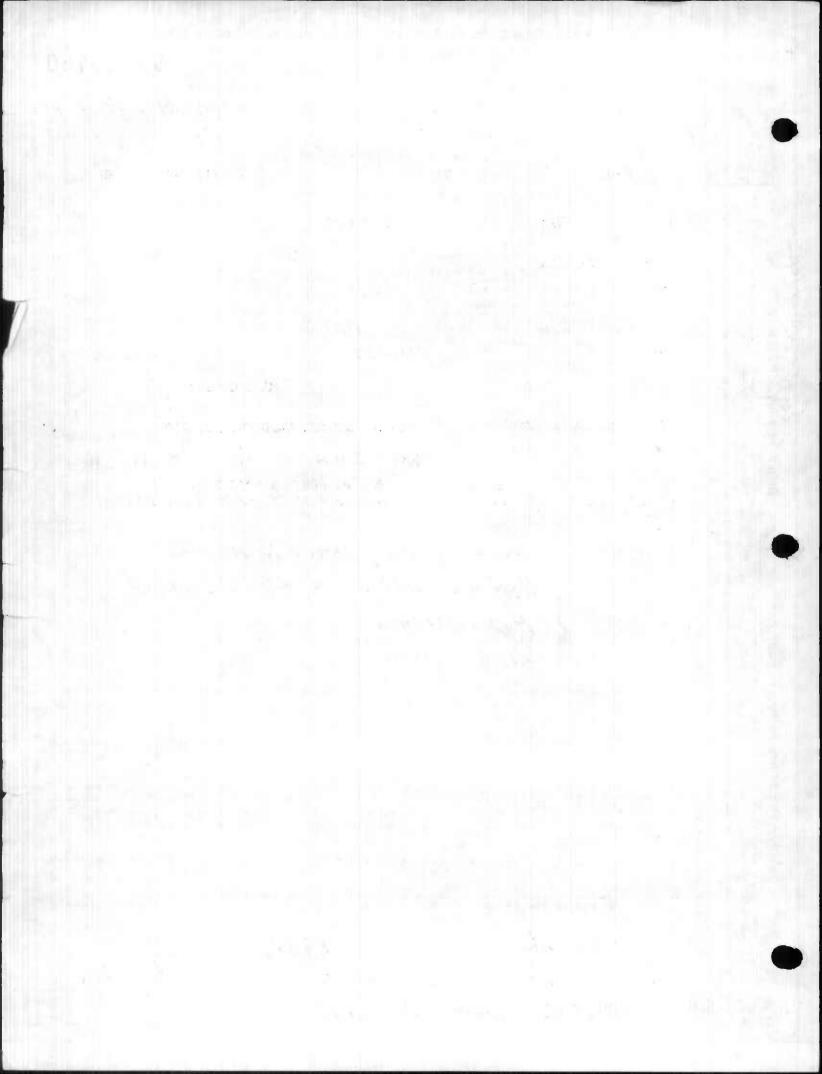
m.D. 0 32. Begistrar's Signeture

29c. Licensa number

General

29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM#23a PER MD G775 9/24/99 AH 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2. Date of Deeth Month **Physician** 25 B BRIGHTMAN AUG.UST 4:00 AM ALLEAN 1999 /Medical 4b. Cify, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** PIKESVILLE NURSING + CONVALESCENT MIKESVILLE BALTIMORE If Under 1 Year Deys Hours Min. April 20,1910 Texas 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 F Yrs. 89 463-86-7154 Director Usual Residence of Decedent the Maryland r 28a-f ehow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 Item 27 is marked other than "natural", or items 23a or other traumatic event, one Moulcal Examinar must be a 505 Sudbrook Ln 21208 permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Heelth and Mental Phygiene. Important: If flam 27 is marked other than "natural", or litema 23s any injury or other traumatic avant United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: p 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Dalah Texas Eoof Jessie Alford Bettis 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Berta Brightman/Daughter 505% Sudbrook Ln Baltimore, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State Green Mount Crematory 8-26-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 23a. Pert1. Ent r the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. 8717 Green Pastures Dr., Baltimore MD 21286 Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical - DEMENTIA DINIL Examiner Due to (or es e consequence of): Examiner HYPONATREMIA physician end s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, c. ANEMIA certificate be Physician/Medical Due to (or es e consequence of). 80 **BSD** Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. the 2 1 Yes 2 No 3 Probably signed t Records, þ 24b. Were sutopsy findings evailable prior to 24e. Wes an eutopsy performed? Completed peen completion of cause of death? certificate hes 1 Yes 1 Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: SONO Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After Neturel 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours a Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one)

29c. License number

4768

Bustestown

MD

29d. Dete signed (Month, Day, Year)

21134

8/25/99

State Registrar 29b. Signeture end title of certifier

31. Date filed (Month, Day, Year)

nd

AUG 26 1999

Miller

Muli

30. Name and access of person who completed cause of death (Item 23a) (Type, Print)

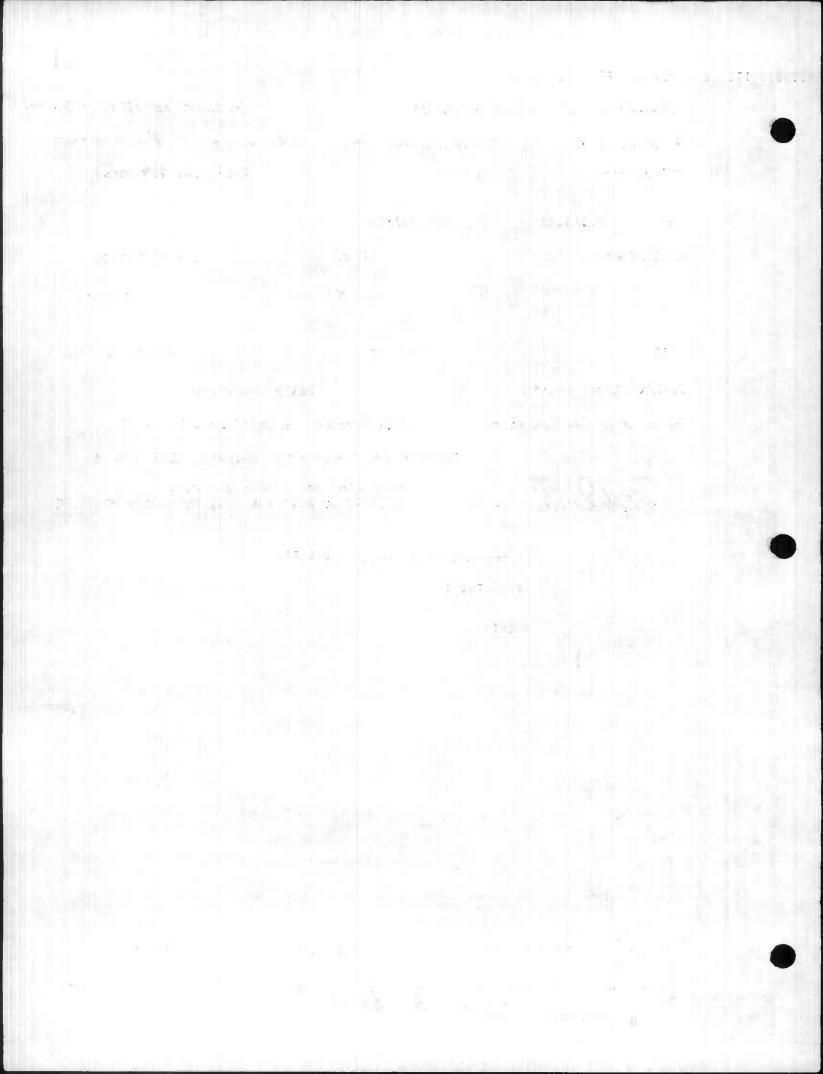
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32. Registrer's Signature

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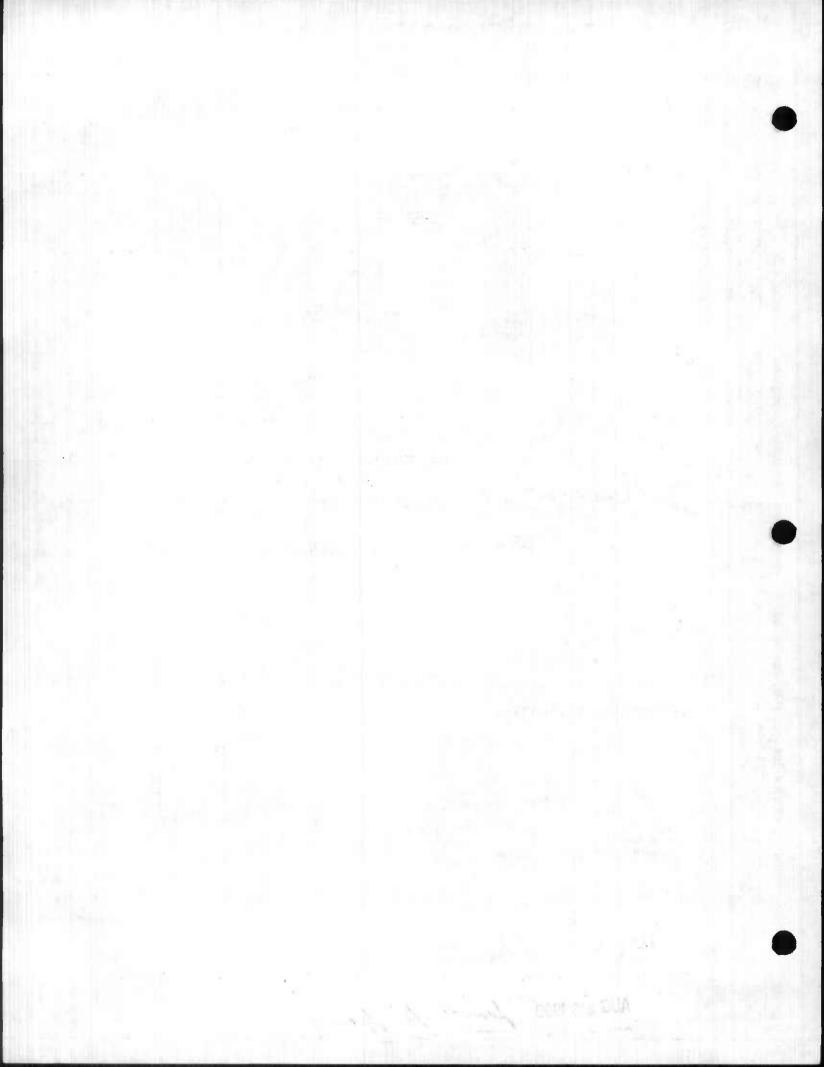


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B.K.S GLADYS BRI	State of Maryland / Department of He	looth	00 20710										
GEADIS DIG	1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death										
Physician		Month D	1999 1804 PM										
/Medica Examine	Gladys L. Bristow 4e Fecility Neme (If not institution, give street and number) 4b		Ic. County of Death										
	SINAI HOSPITAL E.R.	BALTIMORE											
Funeral	5. Social Security Number 6. Sex 1 M 2 T F 7. Age (In yrs. last birthday) Wrs. last birthday) H Under 1 Yeer Months Days	If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)										
Director	218-26-8785 67 Yrs.	05 09	32 S.C.										
and war	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits										
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death with the Manyland ms 23s or 28s-f show threat be notined at	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Country?										
th wit		5	U.S.A.										
020 urs after ur, or he	If Yes, Give 1 1 ☐ Yes 2 ☑ No Year or Dates:	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indien, Black, Whita, etc. Specify: Black										
15-002 72 hours "netural",	15. Decedent's Education 16a. Decedent's Usual Occupal (Specify only highest grade completed) (Give kind of work done du	ion 16b.	Kind of Business/Industry										
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Te a la l	Erwin House-Son 3902 Edgewood Rd, Baltimore Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State												
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oxificate be associted ding physician and use as the burial-transit	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):												
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- 0 0 %	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	in Pert I. 23b. Did tobacc	co use contribute to the cause of death?										
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Of Vital I Physicien: The this certificate ral director, page Co.: To Be Co.		26. Place of Death (Check only one)											
the second	1 Inpatient AMERICOUtpatient 3 DOA	4 Nursing Home 5 Hesidence											
E 5 5 5 6	27. Manner of Deeth \(\frac{\tau}{\text{VNtetural}} \) 2 \(\text{Accident} \) 3 \(\text{Suicide} \) 3 \(\text{Suicide} \) 48. Date of Injury (Month, Day Year) 28b. Time of Injury Work' 1 \(\text{Year} \) 48. Time of Injury Work' 1 \(\text	es 2 No	ary cocurred										
Divisio Hours after death Funeral Director: A self filled in by the fi	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and City or Town, Ste	and Number or Rural Route Number, ate)										
Hospi R hou Funer	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time (Check only one) 2☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time (Check only one)												
To the comple	29b. Signature and title of certified 29c. License O.C.N		Date signed (Month, Day, Year) UG. 22 , 1999										
Mile	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMPAM A LOW 111 Penn Street.	Baltimore, Marylan	nd 21201										
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		no activit										
3	AUG 2 6 1999 Sepera G. Soul	/											

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 9 9 26743

							Ce	ertificate	of	Death	7		Reg. No	. 00	6) 140	,
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Physic /Med		Howard Ti	heodore	Bra	eckle:	in						Augus	ナラ	4 1	999	9.10	am
Exam		4a Facility Name	(If not institution	n, give s	treet and nu	mber)				4b. City, To	own, or L	ocation of Dea					
		5 L. B	1.	to t	nld	III A				Del	h	ore.		n/a			
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or Name	une	11. Marital Status			Armed Fo		J,S. 13	. Was Decede If Yes, specif	ent of F fy Cub	lispanic Or an, Mexica	rigin? (Sp in, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race Black	 America White, et 		
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		30. Name and add	ress of person	who cor	npleted caus					D 4			,		0.00		
		31. Date filed (Mor	THE DOW Year!	LA	20 0	900 egistrar's Sign		Avenu	е	Balt	imor	e, Mar	yland	1 21	229		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Lester I. Boring, Sr. 9:12 AM August 23, 1999 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Howard 9630 Susies Way 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) 1 M 2 F Months Deys Hours Yrs. 84 205-01-0344 October 31, 1914 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Pennsylvania St. Clair Steward 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 15954 U.S.A. P.O. Box 189; 10th & Hoover Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No tf Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry Steel

Physiclan /Medical Examiner

permit. Pege Department of Important: If any injury or once.

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Baltimore, Maryland

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The law requires that the death certificate be executed

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Examiner Physician/Medical by Completed funaral director, Be Certification: To filled in by

(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Issac Boring Margaret Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1562 Rt. 56 Hwy. East Homer City, Pennsylvania 15748 Ms. Dona Jo Zelensky 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 08/27/99 New Florence, Pennsylvania **Bethel Cemetery** re of Funeral Service 22. Name end Address of Fecility Kenneth A. Stuart Funeral Home 139 Ligonier Street New Florence, PA 15944 int? Enter the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death tmmediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of):

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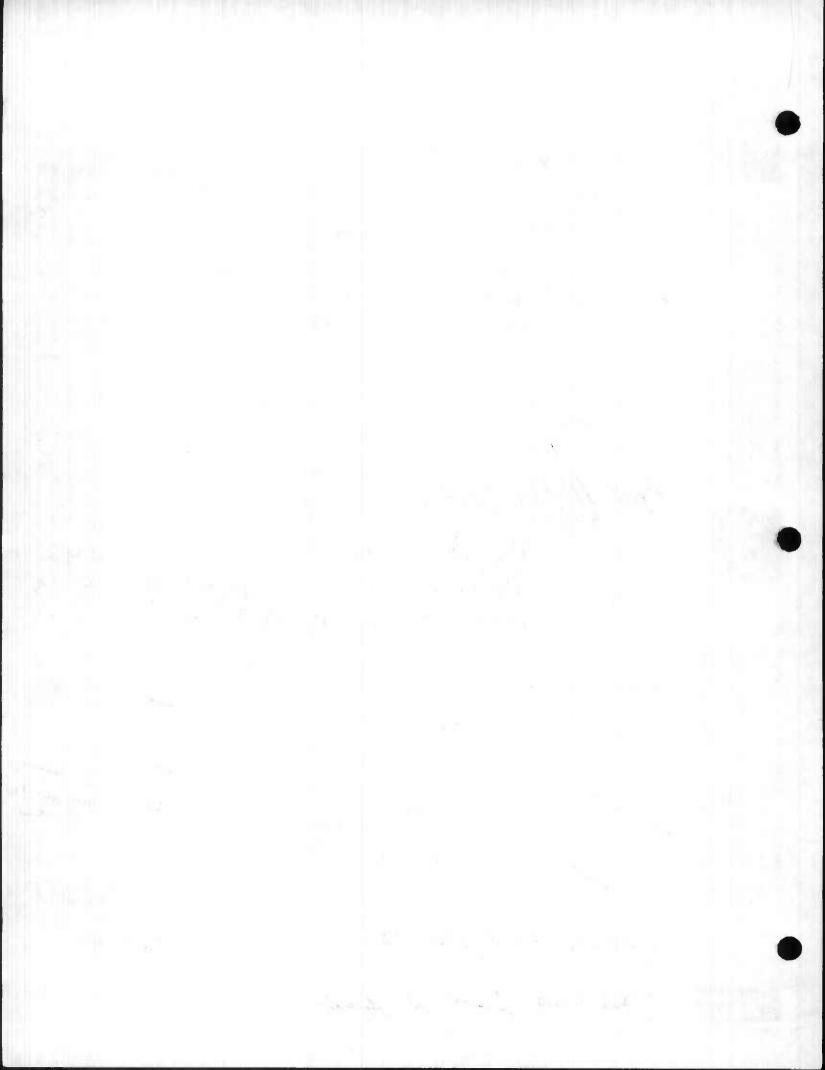
Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 2 TNO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 bother (Specify) grandday Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 ₩0 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) D37011 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

oaks

York-Smith, Kathleen M., M.D. 9501 Old Annapolis Road Ellicott City, MD 21043 32. Registrar'a Signature

State Registrar

DHMH 16 Ray 6/95

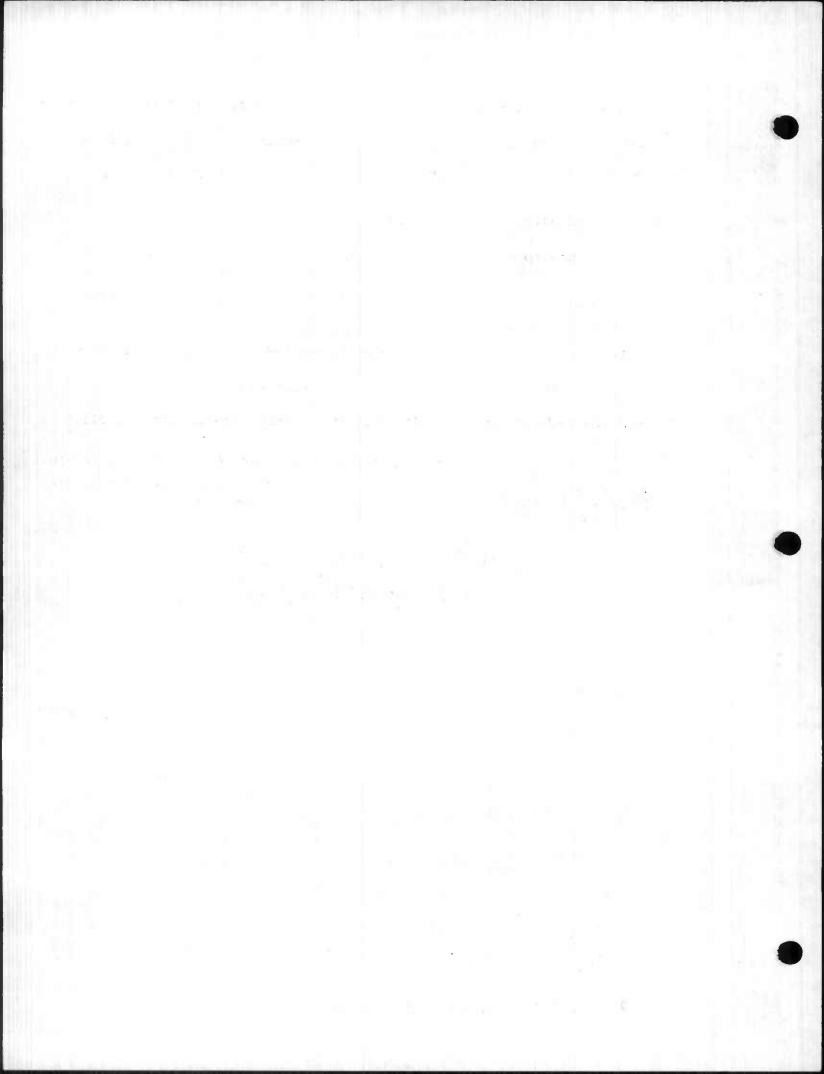


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State of Maryland / Department of Health and Mental Hygiene

						Certificate of	of Death		g. No.	26	745
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L	-21.5		Manor Car 5. Sociel Security Number		ge (In yrs. last birl	hday) If Under 1 Ye	Towson er If Under 24 Hrs.	_		altimor	
	Funeral Director		213-20-5182 Usuei Residence of Decedent	1□ M 2□xF	98 (III yrs. last oil)	Months De		8. Dete of Birth (Month, Dey, Dec. 27	Year) , 1910	Country) Maryl	(State or Foreign Land
	fand		10e. Stete 10b. Count	у	10c. City, Town	or Location				10d. lr	nside City Limits
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	or 28	Director	10e. Street end Number			10f. Zip Coo	е	10	g. Citizen of W	het Country?	
	th wit		509 East Jo	ppa Road		212	86		U.S	S.A.	
21215-0020	hours after death with the Menyland turel', or items 23s or 28s-f show at Examiner must be nutified at	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	It Yes Give	?	13. Wes Decedent If Yes, specify C	of Hispenic Origin? (Sp Luben, Maxican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		- American In c, White, etc. White	
5-0	72 hours "natural".	Completed	15. Deceda	nt's Education est grede completed)	16e.	Decedent's Usuei Oc	cupetion ne during most of work tired)	ring 1	6b. Kind of Bus	siness/Industry	у
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Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of February Service		MOSLI	22. Name end Ad	dress of Fecility				
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	III OU		23e. Pert1. Enter the disee shock, or heert teilure is	r complications the cause	d the death. Do r	1050 Yor	dying, such es cardiec	wson, Mai or respiretory erre	st,		proximete proximete
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ă	after Direction	erti	4 Homicide		c. (Specify)			City or Town,	Stete)		
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	within 3	Me	29b. Signeture end title of certific	er /	11	29c. Lic	ense number	29	d. Dete signed	(Month, Dey,	Year)
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	INE		30. Nema end eddress el ersor	n who completed cause of	Seath (Hem 23a) (Type, Print)	4)0				_/ /
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DHMH 16 Rev 6/95



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State of Maryland / Depa

artment of Health and Mental	Hygiene Q (9 2674	
rtificate of Death	Reg. No.	2014	

			Certi	ficate of	Death	R	eg. No.	201	40
Physician /Medical	1. Decedent's Name (First, Middle, Las	J. Davi	5			2. Dete of Dee Month AUGUS	Dey	Vone	1926 AM
Examiner	4s Facility Name (If not institution, give 911 WEST LOMBARD				4b. City, Town, or BALTIMOR	Location of Deeth	4c. County	1	
Funeral Director	292 JR 10011	7. Age (In yrs		Under 1 Year Ionths Deys			9,1945	9 Hirthplace (State or Foreign
Maryland of show filed at for	Usuel Residence of Decedent 10a. State 10b. County Marvland	10c. C	Ra Hi	ion MARE)				side City Limits √Yes 2 □ No
20 after death with the Maryla or items 23e or 28e-f short miner must be notitiled at / Funeral Director	10e. Street and Number	ard St.		101. Zip Code 2/	223	1	0g. Citizen of V	What Country?	
D	3 ☐ Widowed 4 ☑ Divorced	12. Wss Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		S Decedent of es, specify Cut Yes 2 No	Hispanic Origin? (S pan, Mexican, Puer Specify:	pecify Yes or No- lo Rican, etc.)		e - American Inc ck, White, etc.	lien,
I 21215-0020 ed within 72 hours at yojene. wer than "natural", or At the Medical Exami Completed by F	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)		(Give kin	t's Usuel Occu d of work done NOT use retire	during most of wo	rking	16b. Kind of B	usiness/Industry	ctom
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Balti permit. Departm Importa any inju	pseph ,	L. Russ	1 Jo	Seph	H. Rus	Ave. Bo	ilto.	Home Id. 212	-16 coximete
Physician /Medical Examiner	1 Tosularig at Gootiff	. Arterioscle		rdiovas					vet Between et and Death
68 / 60, trificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Lest	c	or as e consequer						
2 2 4		d						1	
requires that the death cer requires that the death cer nean signed by the attendin hould be deteched for use eted by Physician/N	Pert II. Other afgnificant conditions co		sulting in the unde	rlying cause g	iven in Pert I.		obacco uaa co	ntribute to the d	
ecord aw requir is been s 2 should pleted						24a. Wss e perion INSPE	en sutopsy med? CCTION	svsilable	stopsy findings o prior to ion of cause ?
Sian: The ortificate hoctor, page	25. Was case referred to medical				26. Place of De	1 ☐ Yo	es 2 (XIX)	1 🗆 Yes	2[X No
Of VItal Physician: The properties of the certificate or the Control of the Contr	examiner? 1 X es 2 □ No 27. Manner of Death	lospitel: 1 ☐ Inpatient 2 ☐ 28a. Dete of Injury	28b. Time of	3LI DOA	her: 4 Nursing I	fome 5% Reside			
DIVISION (DIVISION (DIVISION (DIVISION (DIVISION (DIVISION (CERTIFICATION)	1 Meturel 5 Pending Investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Plece of Injury - At houlding, etc. (Speci	Injury nome, ferm, street	M 10	Yes 2 No	28f. Location (S City or Town	treet end Numb n, Stete)	per or Rurel Rou	te Number,
DIVISION OF VITAL HY Tone Hospital or Attending Physician: The is min at A hours after death. To the Funeral Director, After this certificate ha competely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier 1 Certifying Phy (Check only one) 2 Topledical Exami	sician: To the best of my kno ner: On the basis of examins end manner steted.	owledge, deeth oc stion snd/or invest	curred at the t	ime, date end place	e, end due to the curred et the time, d	euse(s) snd ms ate snd place,	snner ss ststed. and dus to the d	ause(s)
To the comp	29b. Signeture and title of certifier	Checte is			se number C.M.E.	2		d (Month, Day, 25, 199	
11/2	30. Name and address of person whe of Dennis Chute M.D.	ompleted cause of deeth (Ite			altimore,	Maryland	1 21201		

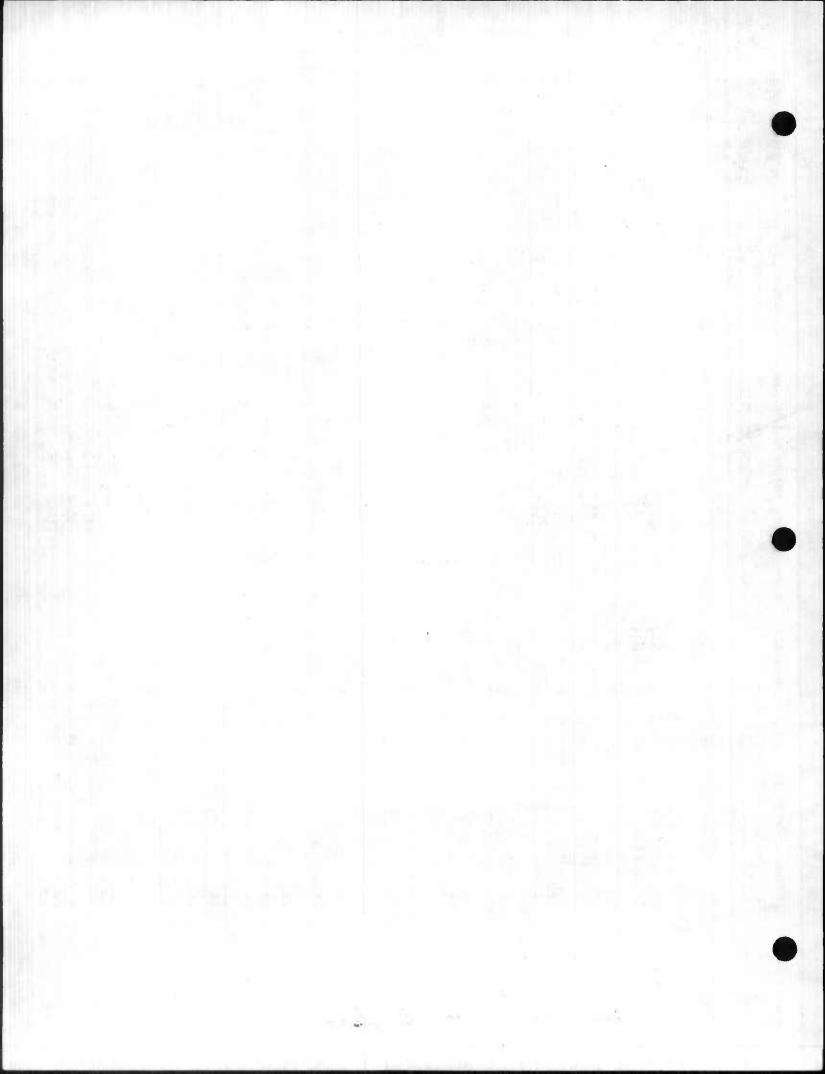
State Registrar

31. Dete filed (Month, Day, Year)

APR A

32. Registrer's Signature

AUG 2 6 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26747 Certificate of Death Reg. No. 2. Pate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 9 /Medical 4c. County of D 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltmur H Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Dec. 31 Hospita Baltimore If Under 1 Yeer 9. Birthplace (Steta or Foreign Washington, D. (5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 579-26-Months 1XM 2□ F Director atient Known to: Gwiltert Daley **Usuel Residence of Decedent** 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No Funeral Director Maryland mor traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23s or 212 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Bleck, Whita, atc. 1 Never Merried 2 Married 1 Yes 2 No MYes, Give Year or Dates: 8 Appeiry: 1 Yes 20 No Specify: λq 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry nd Mental Hygiens. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 SSOT 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 0 71 19b. Mailing Address (Street end Number or Plural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) . 2/20 he 0 0, 20b. Place of Disposition (Nema of cemetery, crematory or other p 20a. Method of Disposition /Date 20c. Location - City or Town, Stete 1 Surial 2 ☐ Cremation 3 Removal from State 6 Ridge 4 Donation 5 □Other (Specify) en 22. Name and Address of Facility Tosoph L. Ru in of Funeral Service/Licens Joseph L. Russ Funer 2222 W. North Ave. Balf caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, one cause on each line. M Balto. Md. 212/6 Approximate Intervet Batween Onset and Deeth **Physician** /Medical Immediate Cause (Final ntracrania 2day disease or condition resulting in death) Examiner Due to (or as a consequance of): Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical 94 Due to (or as e consequence of): 9 Fart II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. å 1 Yes 3 No E 3 Probably 4 Unknown peudis à 2 24b. Ware autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? peen 8 **D8082** 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 88 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 20 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending 5 Pending investiga 1-E Natural 1 Yes 2 No 2 Accident il or Attend ster death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital (within 24 hours at To the Funeral D 29s. Certifie LE Cartifying Physician: To the best of my knowledge, death occurred at tha time, data and place, end due to the cause(s) and manner as stated. Medical the basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, date and place, and due to the cause(s) 29c. License number 29d. Dete signed (Month, Day, Year) of death (Item 23a) (Type, Print) 2401 W. Belvedere

DHMH 16 Rev 6/95

State

Registrar

2---

AUG 2 6 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ern	Please Type or Print in Black Indelible ink. As:	sure All Coples Are L	.egible.	
Shirley Louise Fisher AMEND ITEMS: #23 PART I, 2	State of Maryland Department of Health 27, 28A-F PER MEO G774 8-27-99 Certificate of Deal	h and Mental Hygiene th Reg. No.	99 2	26748
1. Decedent's Neme (F	First, Middle, Last)	2. Date of Death Month Day	Year	3. Time of Deat

/Medical Examiner

Shirley Louise Fisher August 18, 1999 1:30 P.M. 4s Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 1421 Broening Highway Baltimore N/A If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday)

Days

Funeral Director

28a-r

23a or

b

I Hygiene.

Pages 1 and 2 should be fit timent of Health and Mental H tant: If Nem 27 is marked oth jury or other traumatic even

Department of Important: If any injury or page.

Physician

Examiner

burial-trans

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88 use

page 2 s

this funeral

Affac

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3

filled in

completely

death.

hours after death uneral Director:

To the Hospital within 24 hours a To the Funeral C

physician

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

/Medical

Director

Funeral

þ

Completed

Be

The Maryland

filed within 72 hours after

21215-0020

8. Dete of Birth (Month, Day, Year) Feb. 2, 1935 215-30-2476 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location MD N/A Baltimore

10d. Inside City Limits TV Yes 2 □ No

9. Birthplece (Stete or Foreign

Mary Land

10e. Street and Number

21224 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

Months

United States 14. Race - American Indian,

Bleck, White, etc.

10g. Citizen of What Country?

11. Merilel Stetus 1 Never Married 2 Merried 3 Widowed 4 □ Divorced

1421 Broening Hwy

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:

10 M 20 F

1 Yes 2 No Specify.

Hours

Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker

16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last)

Roy Ernest Snyder

Grace Louise Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

18. Mother's Name (First, Middle, Maiden Sumeme)

19e. Informent's Neme/Reletionship (Type, Print) Norman Snyder/Brother

3546 Keswick Rd Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, cremetory or other place)

Domestic

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify)

Green Mount Crematory

20c. Location - City or Town, Steta 8-23-99 Baltimore, MD

21. Signature of

22. Neme end Address of Fecility CAFA Stephen D. Lohrmann P.A.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286

Immediate Cause (Finel disease or condition resulting in deeth)

ALCOHOL AND NARCOTIC INTOXICATION

Due to (or es a consequence of):

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In death) Last

Due to (or es a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

23b. Did tobacco use contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

24b. Were eutopsy lindings available prior to completion of cause of death?

Approximete Intervel Between Onset and Daeth

1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\mathbb{I}\$ Residence 6 Other (Specify)

1 Yes 2 No

25. Wes case referred to medical axaminer? 1 XYes 2 No

27. Menner of Death

1 Neturat

3 ☐ Suicide

2 ☐ Accident

4 Homicide

FOUN Month, Day Year) 5 Pending investigation 8-18-1999

6 🖾 Could not be determined

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of tnjury OUND 1:24

28e. Ptece of Injury - At home, larm, street, fectory, office building, etc. (Specify)

RESIDENCE

28c. Injury at Work? P М 1 Yes 2 No 28d. Describe how Injury occurred UNKNOWN

28f. Location (Street and Number or Rural Route Number City or Town, Stete) 1421 BROENING HIGHWAY, BALTIMORE, MD.

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and little of certifier

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) August 18, 1999

wo

61999

HEUDOREMIKEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Ray 6/95

Baltimore, Maryland Box 68760. P.O. Records, of Vital Division

The law requires that the deeth certificate be executed

or Attanding Physician:

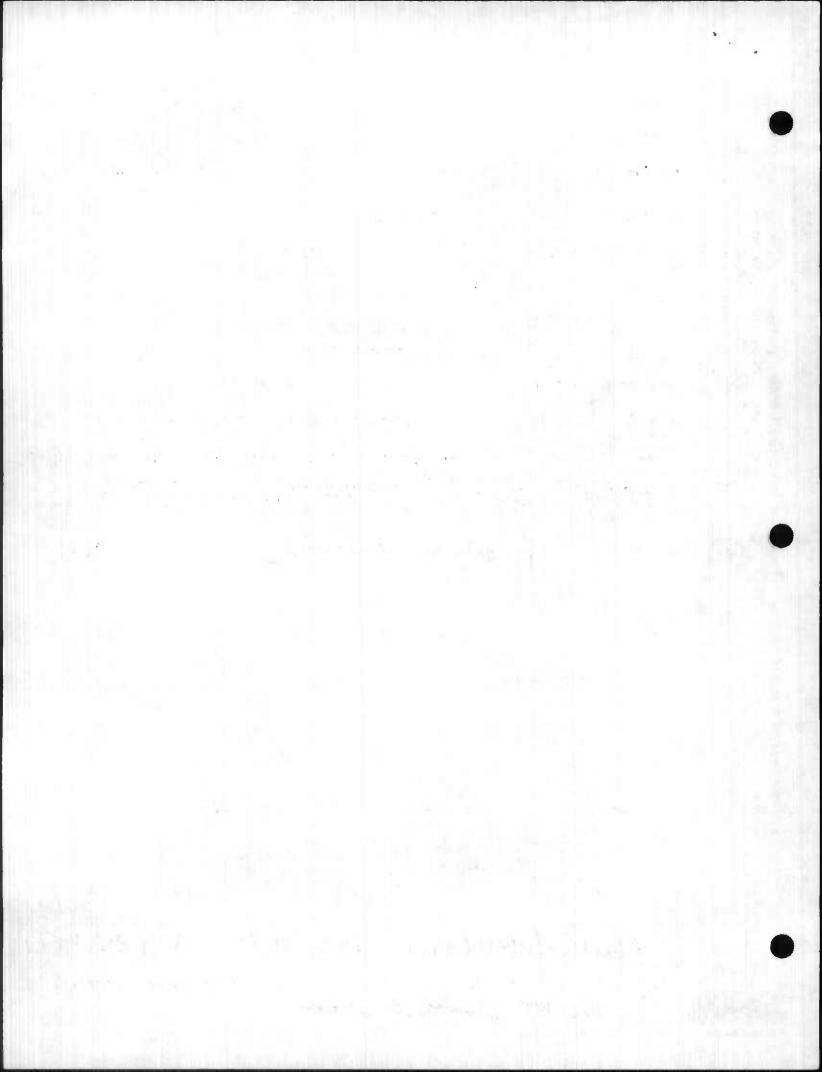
The Thirth Artes

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State of Manyland / Department of Health and Mental Hygiene O

	•		Certifica				leg. No.	26) /49
	Di		1. Decedent's Nama (First, Middle, Last)			2. Data of Dea Month		Yaar	3. Time of Death
8	Physici /Medic	al	Charles G. Fitzhugh, Sr.			August	24, 19		11:00 PM
À	Examin		4e Facility Name (If not institution, give street and number)		4b. City, Town, or L		4c. County		
			6410 Walther Avenue 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 11 Under	er 1 Yaar	Balti If Under 24 Hrs.			N/A	place (Stata or Foraign
	Funeral Director		216-14-7807 Usual Rasidance of Decedant		Hours Min.	8. Data of Birth (Month, Day OCt. 4	1914	Mary	land
	yland Mand		10a. Stata 10b. County 10c. City, Town or Location					1	10d. Inside City Limits
	Mar	ctor	Maryland N/A Baltimore						¹X Yas 2□No
	death with the Maryland ms 23s or 28s-f show Emist be notified at	Dire	10e. Street and Number 10f. Z	ip Code			log. Citizen of	What Cour	ntry?
	ath w	rai	6410 Walther Avenue		21206		Unite		
020	of the	by Funeral Director	1 Nevar Married 2 Married 1 ☐ Yas 2 No		Hispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ck, Whita,	
21215-0020	n 72 hours of natural", c	Completed	15. Decedant's Education 16a. Decedant's Usi (Specify only highest grada completed) (Giva kind of w	ual Occup	pation during most of work	ina	16b. Kind of B	usiness/In	dustry
121	d within plena. r than "	mpie	Elementary/Secondary (0-12) Collega (1-4or 5+)	use retire	d)				
	Hygle ther ther ther	S	12 Securit	y Gu	18. Mother's Nam	a (First Middle		kerto	n
Maryland	Mental I	o Be	Charles H. Fitzhugh		Ethel	Blain		,,	
ary	SPEE	F		ss (Street	and Number or Rui		r, City or Town	, Stata, Zij	o Code)
-	1 and 2 Health a em 27 le		Edna Saynuk / Friend 622 S. P	ort	Street B	altimore	, MD 2	1224	
altimore,	Te Te Te		20a. Mathod of Disposition 20b. Piece of Disposition (Ne cematary, cramatory or	ame of other pla	ce)	Data	20c. Location	City or To	own, Stata
Ĕ	Pages nent of ant: If it ury or o		1X Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) Dulaney Valle	- Calle		s 8/28/9	9 Timo	nium,	Maryland
Rail	permit. Pages Department of I Important: If ite any Injury or o pncs.				. Ruck, I ord Road	nc. Fune	eral Hou	me 2121	4
			23a. Parl 1. Enter the district, or complications that caused the death. Do not enter the moshock, or heart tails in List only one cause on each line.					-121	Approximata Intervat Batween
	Physician								Onset and Death
	/Medical Examiner		Immediata Cause (Finel diseasa or condition rasulting in daath) a. prostale cancer m	icta	stahe			- (991
		P.	Dua to (or as a consequence of					1	
	urted	Examiner	b	D.				1	
'n	flicate be executed physician and as the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury).					
58/60,	nte be nysicia he bu	edlcai	Cause (Diseasa or injury that Initiated evants resulting in deeth) Last Dua to (or as a consequence of)):					
_			Tooding in Good Last					1	
ROX	eath certifi ettending I for usa as	lan	0.						
o .	the death cert y the ettendin ached for use	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying	ceuse gi	ven in Part I.				to the cause of death?
7	that the detail	F				101	as 200 MG	3 Pro	obably 4 Unknown
cords,	v requires that the de been signed by the should be detached	by by				24a. Was a	an autopsy	24b. W	/ere autopsy findings
000	law req	olete				perfor	med?	CC	vailable prior to ompletion of cause death?
Ž	sician: The law certificate has l lirector, page 2:	Completed				1 D Y	as 20 No	1	□Yes 2tŽNo
Vital	an: T	Bec	25. Was casa retarred to medical		26. Place of Dea	th (Check only or	ne)		
01 <	Physician: this certific ral director,	2	exeminer? 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D	DOA Ott	her: 4 Nursing Ho	oma 5 Resid	ence 6 □Otl	har (Speci	fy)
<u>_</u>	tending Physician: Seath. tor: After this certific the funeral director,	OU:	I Shiftigal O Transing	28c. Inju Wo		28d. Describe h	ow injury occur	rred	
JIVISION	tor: A	cati	2 Accident invastigation 3 Suicide 6 Could not be		Yas 2□No	29f Location /6	treat and film	har or Pur	al Routa Number,
<u> </u>	or Attending P safer death. I Director: After d in by the funer	Certification:	datarmined 4 Homicide datarmined 28a. Place of Injury - At home, farm, street, factor building, atc. (Specify)	ry, onice		City or Tow	n, Stata)	Der Or Fran	arriota rumber,
Ŧ.	apfta nours meral		29a. Certifiar 1D Certifying Physician: To the best of my knowledge, death occurred	d at tha ti	me, date and place,	and due to the d	ause(s) and m	enner as t	stated.
	To the Mospital or Attributed to the Tothe Funeral Direct completaly filled in by	edical	(Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigetion and menner steted.						
	To the state of th	Ž			se number		29d. Data signe	d (Month,	Day, Year)
	12		Nancy were mp	200	05307	0	Aug	.25	, 1999
-	1/4		30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)				#B:	156	
1	NV		Dr. Daniel Laheru 600 N. Wolfe Street 31. Data tiled (Month, Day, Year) 32. Registrar's Signatura		timore, M	D 21205	Oncol	ogy C	enter
	Sta Registra		31. Data tiled (Month, Day, Year) AUG 2 6 1990 32. Registrar's Signatura	pou	Kat				

Registrar DHMH 16 Rev 6/95



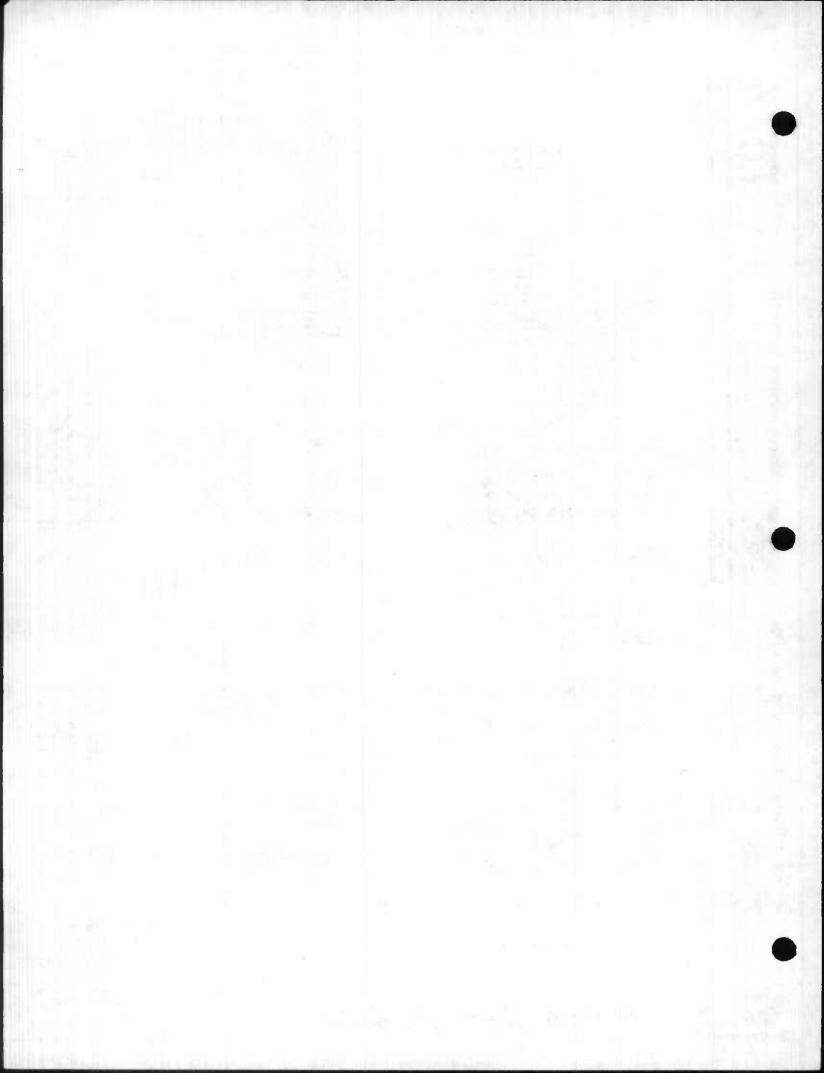
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State of Maryland / Department of Health and Mental Hygiene 99 26750

					Ce	ertificate	of L	Death		8	leg. No.		-01	00	
		1. Decedent's Name (First, Middle	e, Last)						2. Date of Death			3. Time	e of Death		
Physi		William Frederick Gardner Ir								AUGUS'	Day Γ 24, 1	Year	7:	19 PM	
/Med		4a Facility Name (If not Institution			LION	Jarane				cation of Death		y of Death		r 5 ETI	
Exam	iner	Anne Arundel			o r									1	
	_	5. Social Security Number	6. Sex	7. Age (In yrs		al If Under 1	-	Anna			Anne				
Funera		500-38-4047	M 2□F	60	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day	Year)			te or Foreign	
Directo	r	Usual Residence of Decedent	Λ	00	7100					SEP 5,	1938	MIS	ssou	rı	
pu *		10e. State 10b. County		10c C	ity, Town or L	neation						T.	10d Insid	e City Limits	
anyla ah	-	Missouri Jasp	per		Jaspe					1 Yes X No					
2 2	oct				T T									7,211	
5 6	금	10e. Street and Number				10f. Zīp C					l0g. Citizen of	What Cou	ntry?		
₽ 53m	8	211 N. Main S	street			64	+75	5			USA				
17215-0020 within 72 hours after death with the Maryland one. then "natural", or terms 23e or 28e-4 show the Maryland and	by Funeral Director	11. Marital Status	Armed F	cedent Ever in I		Was Decede	ent of His	spanic Ori	igin? (Spi	ecify Yes or No- Rican, etc.)		ce - Ameri		١,	
O # # #	F	1 Never Married 2 Marr	ied 1 Yes	2 No. 9			Yes, specify Cuben, Mexican, Puerto R Yes 20 No Specify:						eic.		
21215-0020 d within 72 hours af giene. rr than "natural", or the Wroteral Energy		3 Widowed 4 Divorced	Year or I	Dates: 196	53	111 165 24	טאו בל	Specify.			Speci	Wh.	nite		
2 ho 2	Be Completed	15. Deceden	t's Education		16a. Dece	edent's Usual	Occupe	tion	A = 4 a du		16b. Kind of E	Business/In	idustry		
F 6 6	ple	(Specify only higher		/ (1-4or 5+)	lile.	e kind of work DO NOT use	retired)))	t or work	ng					
N N N N	Eo	Elementary/Secondary (0-12)	Comage	(1-101 31)	Coc	ok					Rest	aura	nt		
Hygina Hygina	0	17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	e (First, Middle,					
Maryland of 2 should be file the and Mental Hy it is marked other traumatic avant	To B	William	Frederi	ck Gar	dner.	Sr.		Vi	reir	nia M.	Johns	on			
should Ind Meni	F	19a. Informant's Name/Relations			-	<u> </u>	Street o			al Route Numbe			n Code)		
Baltimore, Maryland 212. Demit. Peges 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than my Injury or other traumatic avent, the Mental													, 0000)		
B, R l and Health m 27 her tr		Donald C. Gar	dner, S	r./brot	ther 2	osition (Name	lain	Stre	et	Jasper,	MO 64 20c. Location	755	- Cana		
SALUMOTE, Semit. Peges 1 a. Department of Hea mportant: if Nam.	117		3 Removal from	State	cemetery, cre	ematory or oth	ner place	-	1.		20G. LOCATION	- City or 1	DWII, State		
Peg ment uny o		1 Burial 22 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other place) Metro Crematory, Inc. 08/26/99 Ball											, MI)	
Demit. P Departm Importan		21. Signature of Funeral Service	Licensee	0-0	2	22. Name and	Addres	s of Facili	ty .						
n ages	3	Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228													
_		23a. Part1. Enter the disease, or	Tomolications that	Caused the des	th Do not er	299 H	of thing	eri	CK F	d. Ba	timor	e, M	Approxi	1228_	
V. 1		shock, or heart failure. List	only one cause on	each line.				,				1	Interval	Between nd Death	
Physician /Medica		Immediate Cause (Finat	1	,		1 10						1			
Examine		disease or condition resulting in death)	ah	emorth	agic :	shock	_					<u> </u>			
		rooming in doding		Due to	or as a conse	equence of):									
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cute	Tem	Sequentially list conditions, if any, leading to immediate		Bue to	or as a conse	equence of):									
Lie C	m i	cause. Enter Underlying	6	Puntul	00 AV	demin	1100	Anto	A	newysv	1	t			
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o ph o ph os th	8	resulting in death) Last										İ			
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that the death cered by the attendin	Physician									1				44.40	
. 0 0 %	ys.	Part II. Other significant condition	ns contributing to o	death but not re	sulting in the	underlying cau	use give	n in Part	l.	23b. Did t	obacco use c				
Tet de										101	es 2 No	3 Pro	ibably 4	I Unknow	
0 2 52	Completed by											T			
v require	Pe									24a. Was perfo		20	vailable pr	sy findings for to	
s be	De e				-				_			of	ompletion death?	of cause	
The law ste has b page 2 s	E									101	es 2DNo	1	☐ Yes :	2∏ No	
delan: The certificate rector, pag	Ü	25. Was case referred to medical						00 Dt	4 04						
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hour hour y fill	8	29a. Cartifier 1 Certifyin	g Physician: To th	e best of my kn	owledge, dea	th occurred at	t the tim	e, date ar	d place,	and due to the	ause(s) and n	nanner as	stated.		
To the Moapital or Atlanding Physician: The I with 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one) 2 Medical 1	Examiner: On the t	pasis of examin nner stated.	ation and/or in	nvestigation, ii	n my op	vinion, dea	ith occur	red at the time,	sate and place	, and due t	the caus	se(s)	
A STATE	X	29b. Signature and title of certifier				29c.	License	number			29d. Date sign	ed (Month,	Day, Yes	nr)	
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110	()	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN D. MARTIN 104 FORBES STREET ANNAPOLIS													
1	Ĭ	JOHN	D. MAK			rbe) 2	183		, , , ,	.,,,,,,,					
S	tate	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign	atura										
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26751 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT LEE S. HYMAN 24 08 99 14:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Maryland 21215-0020 HS: Robert Hyn Sinai Hospital of Baltimore Baltimore 5. Social Security Number 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Hours Yrs Director 218-10-9505 79 AUG. 1,1920 Usual Residence of Deceden 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director 1X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6320 GREENSPRING AVENUE #106 21209 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black White etc. 1 Never Married 2 Married 1XXYes 2 □ No If Yes, Give Year or Dates: ö 1 ☐ Yes 2 X No Specify: WHITE by 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON WHOLESALE LIQUOR marked other reportant: if New 27 is marked by any Injury or other 27 is marked. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CALVIN HYMAN ROSE SAGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERTA HYMAN / WIFE 6320 GREENSPRING AVE. #106 - BALTIMORE, MD 21209 altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXurial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO ARLINGTON 8/26/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 see or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Multisystem Organ Failure 72 hr Due to (or as a consequence of): Sepsis 7 days Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hematuria 14 days Box 68760 certificate be Physician/Medical Due to (or as a consequence of) Transitional Cell Carcinoma of Bladder l month for u Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the causa of death? 3 1 Yes 2 No 3 Probably 4 Unknown Records, þ sign be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 X No 1 Tyes 2 No of Vital Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica staly filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending Investigation 1 Tyes 2 No 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) P09785 08/25/99

State Registrar 31. Date filed (Month, Day, Year)

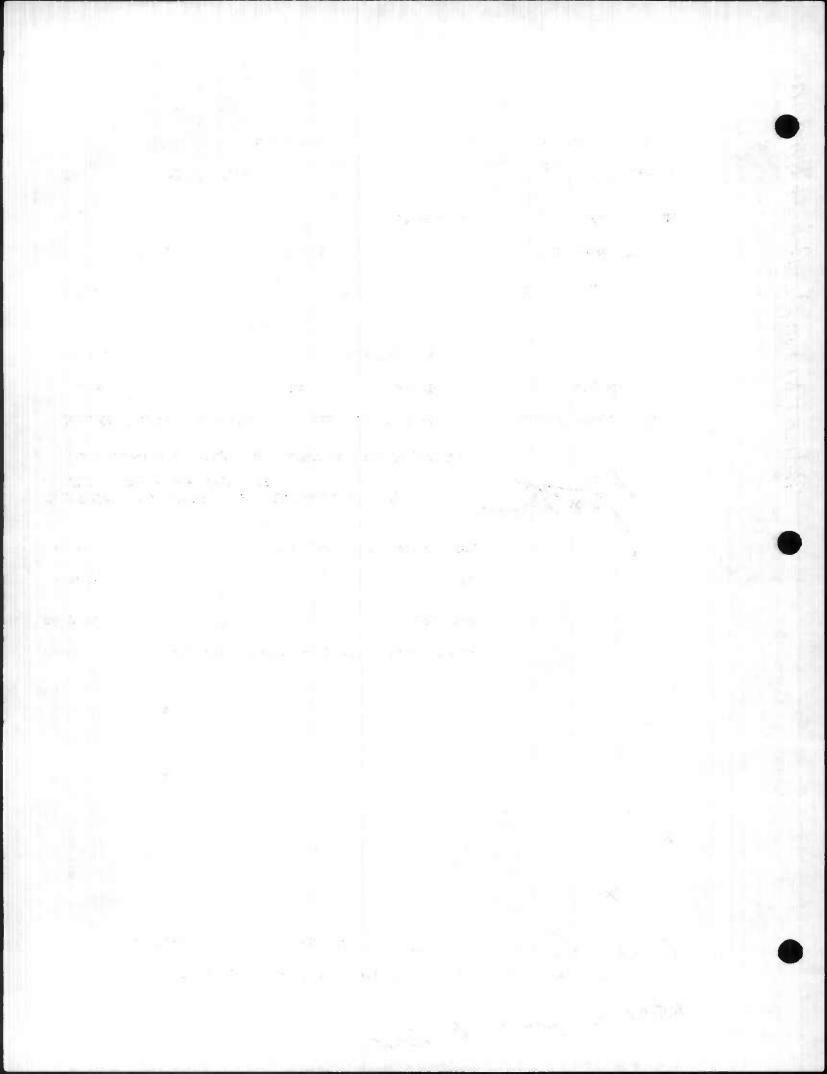
32. Registrar's Signature

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b. Sparks

ame and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah Glassman, 2401 W. Belvedere Ave., Baltimore, Md. 21215

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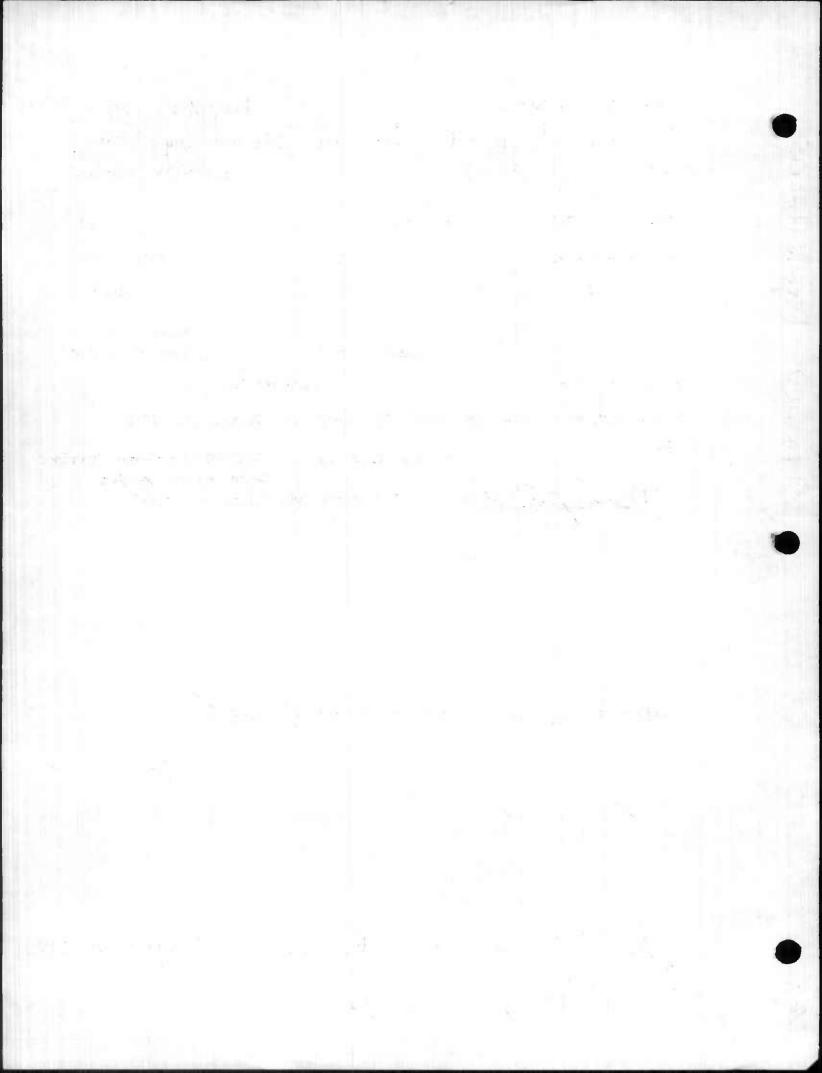
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Norma Loretta Harris Avaust /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DALTIMORE BAITIMORE CHU N/A 0 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2 F 220-36-6777 58 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No must be notified Director 28a-f. Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 3412 Duvall Ave. Funeral 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) event, the Medical Examiner 1 Never Married 2 Married Specify: Black ð 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Foster Care Elementary/Secondary (0-12) College (1-4or 5+) 12 th Foster Parent State Of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Albert McDuffie Margaret Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) # Shirley D.M.Harris -Wms. (Daughter) 3412 Duvall Ave. Balto., Md. 21216 Nem 27 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removel from State 20c. Location - City or Town, Stata 8 8/28/99 Landsdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility Caple Funeral Service 5502 Winner Ave. Balto., Md. 21215 nat caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, terval Bety Onset and Death Physician Immediete Cause (Finel diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): that the death certificete be exec Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 Yes 2 No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records, The law requires 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? certificate Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1□ Yes 2☑ No 1/ Inpatient 2 ER/Outpatient 3 DOA this s ofter death. i Director: After this od in by the funeral di 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Netural 5 Pending investigation tnjury 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 I Homicide To the Hospital o within 24 hours of To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. Medical 29a. Certifian 29b. Signature and title of corpill 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (MATU

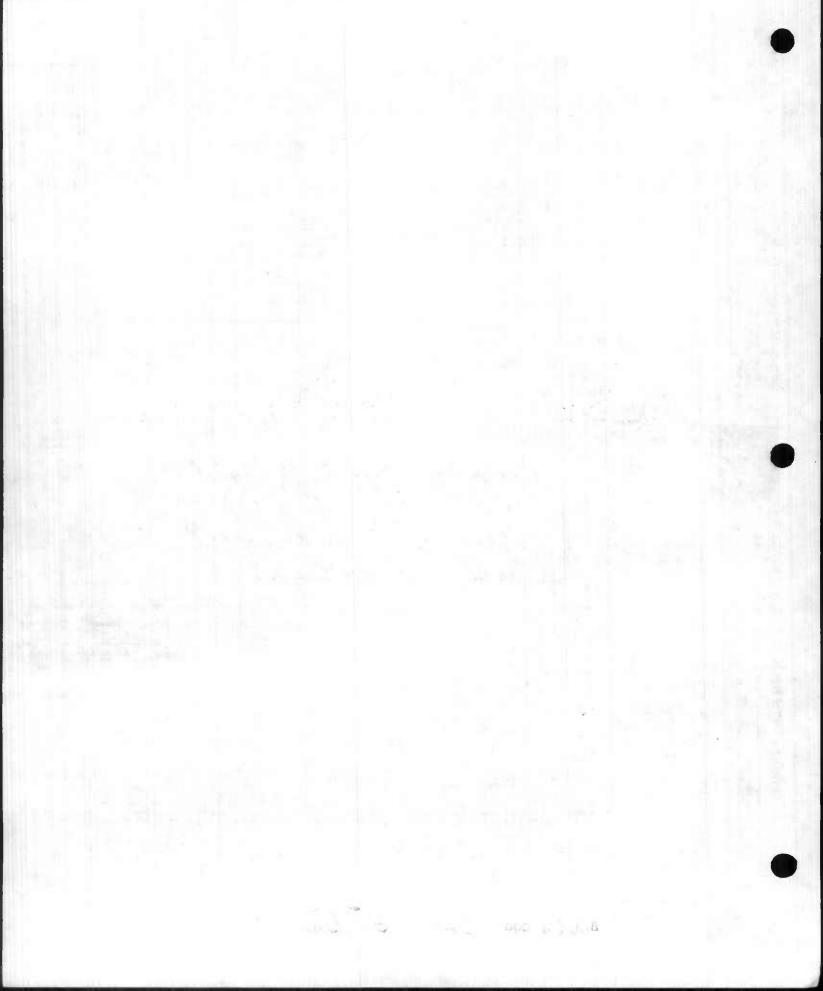
32. Degistrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 9 26754

			Cer	tificate of	Death		Reg. No.	C (0109	
	1. Decedent's Name (First, Middle, Last			2. Date of D						
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/Medical	4a Facility Neme (If not institution, give			1	4b. City, Town, o	or Location of Dea			7.33 TM	
Examiner										
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Funeral	5. Social Security Number 6. Se	7. Age (In yrs. la	1115.00	Months Days	Hours M	n. 8. Date of Bi	rth ay. Year) 28, 1918	9. Birthpla Counti	ace (State or Foreign	
Director	217 03 3217	80	Yrs.			Sept.	28,1918	Mary	iland	
2 .	Usual Residence of Decedent 10a. State 10b. County	40- 04-	Town or Loc					1.00		
at on H	10a. State 10b. County		100							
A Page of	Maryland N/A		Bo	altimore					VL Yes 2 No	
or 28a-f	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Countr	ry?	
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her death v r herre 23 iner met	11. Meritei Status	12. Wes Decedent Ever in U.S	. 13 V	Vas Decedent of H		(Specify Yes or N				
The Day	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 🕅 No	tf	Yes, specify Cube	an, Mexican, Pu	erto Rican, etc.)	Black, While, etc.			
21215-0020 d within 72 hours at gene. rr than "natural", or the Medical Exam?		If Yes, Give	1	☐ Yes 2 No	Specify:					
9 m m p		Year or Dates:					Black, White, etc. Specify: White 16b. Kind of Business/Industry Aerospace Defense a. Maiden Sumame) gs ber, City or Town, State, Zip Code) 2. Maryland 21213 20c. Location - City or Town, State Baltimore, Maryland Inc. ore, Maryland 21213			
21215-0 ed within 72 ho spiene. er than 'netur t, the Medical. Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give I	ent's Usual Occup kind of work done OO NOT use retired	ation <i>during most of</i> w	vorking	16b. Kind of Bus	iness/Indu	ustry	
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Vial Menta Menta Mine Mine Mine	Frederick Hallame	yer		100	Edna	Stallin	98	Aerospace Defense Addiden Sumame) City or Town, State, Zip Code) Maryland 21213 Coc. Location - City or Town, State Baltimore, Maryland C. Le, Maryland 21213 Approximate Interval Between		
T SEE .	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Meitin	g Address (Street	and Number or	Rural Route Numi	ber, City or Town, S	itate. Zip (Code)	
E Sasa	Christine B. Hallo	mayor William	2205	Shannon 1	Deino 1	2altimate	Manula	nd n	1012	
e Tage	20a. Method of Disposition			sition (Name of	vice, i	Date				
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A Pour	21. Signature of Funeral Service Licens		22.	Name and Addre	ss of Facility					
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e	23a. Pert1. Enter the disease or complishock, or heart failure. It all only of	ne ceuse on each line.	DO NOT GIAC	and mode of dyn	19, 0001 00 0010	ac or respiretory	3,11001,	. 1	Interval Between	
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/Medical Examiner	Immediate Cause (Final disease or condition	ilyr	0	1	years					
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	examiner?	Hospitel:	R/Outpatient	3 DOA Oth	er: 4 Nursing	Home 5□ Res	idence 6 Other	(Specify))	
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To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying Physical Example 2 Medical Example	sician: To the best of my knowl ner: On the basis of examination	ledge, death	occurred at the tin	ne, date and pla	ce, and due to the	date and place at	ner as sta	the cause(s)	
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14.0	30. Nama and address of person who co	ompleted a se of death (Item 2	23a) (Type, F	Print)	· Marker	1011	Ospvill	DU.	Balor	
2 /2	CAKLOS E.	MALL OF HALL	77. 2	1-6	NORTH	orly 1	11/1/10/	11 1	ma cicit	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** August 24, TILLIE AGNES HEINE 8:45 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1200 Dranmore Way Bel Air Harkord If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 10 M 20 F Months Feb. 16. 1908 215-54-3501 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yas 2 No Director 280-1 Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1200 Dranmore Way 21014 U.S.A. Nerns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Detas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifal Status Bleck, White, etc. 1 Nevar Merried 2 Merried the Medical Exami Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Owner/Operator Grocery Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 Pages 1 and 2 should be 1 sent of Health and Mental I Francis Janda Agnes Sola 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Department of Health I Important: If Item 27 Is any Injury or other tra 1200 Dranmore Way. Mildred Harrison (Daughter) Bel Air, MD. 21014 20e. Method of Disposition 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 A Burial 2 Cremetion 3 Removel from Stete 8/27/99 4 □ Donetion 5 □ Other (Specify) Most Holy Redeemer Cem. Baltimore. Maryland 22. Name and Address of Fecility
Schimunek Funeral Home of Bel Air, 21. Signeture of Funeral Service Licenses 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Chronic Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) physician the burie Box 68760, Due to (or as a consequence of): USB P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 20100 1 Yes 20 NO of Vital 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 26a. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Division or Attending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Scartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signetura end fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) By How, MD ZIZZE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State

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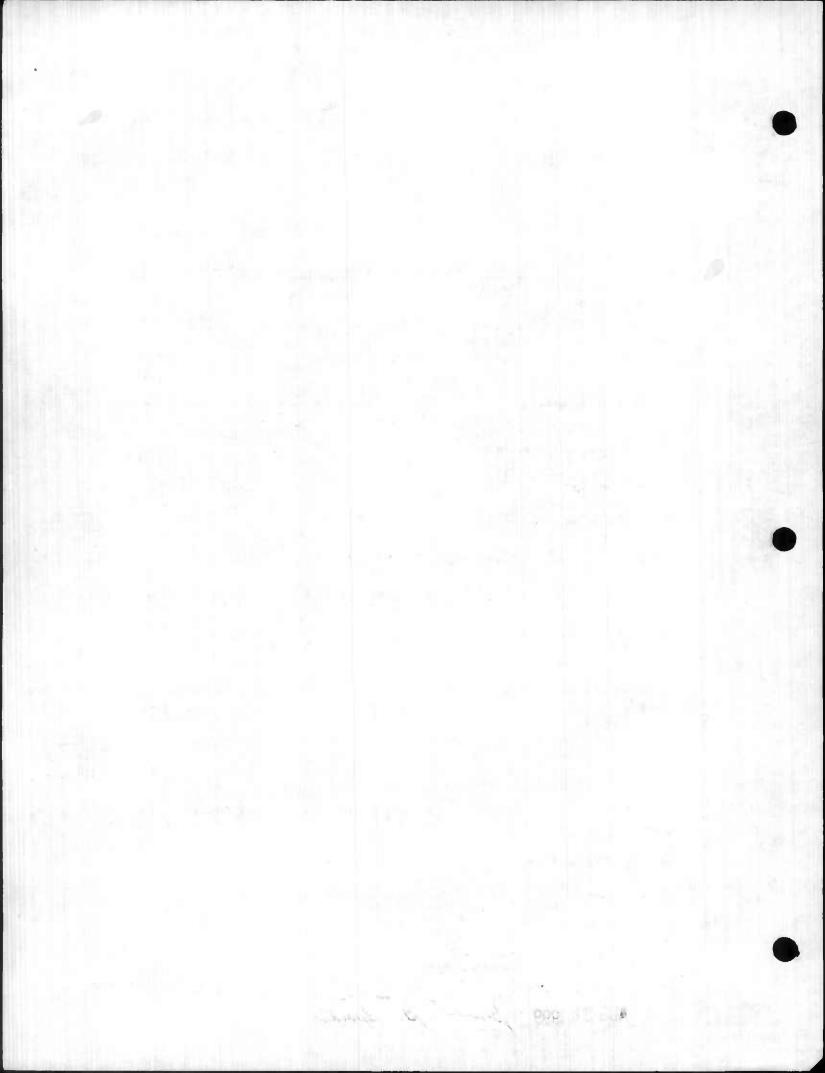
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32. Registrar'a Signatus



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			Decedant's Nama (First, Middla, Last)		Cert	illicate oi	-	Reg.	No.	2.1	ima of Death	
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		ıer	STELLA MARIS HOSPICE	un bory			TOWSON		BALTI			
-	Funeral		5. Social Security Number 6. Sax	7. Aga (In yrs. la	st birthday)	If Undar 1 Year Months Deys		ta of Birth onth, Day, Ye		9. Birthplace /	Stata or Foreign	
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	rai	175 WIMBLETON WAY	17356		U	S.A.						
	by Funeral	11. Maritel Stetus 1 □ Navar Married 2 Married 1 □ Navar Married 2 Married 1 □ Yes 2 □ No If Yes, Give			13. Was Decedant of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 1 ☐ Yas 2 ☑ No Specify:				Bleck, White, atc.			
2-0020	houn		3 Widowed 4 Divorced Yaar or	Datas:						WHII	Ľ	
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	o Be	CHARLES HESS				KATHLEEN H			/			
ary	s 1 and 2 should be I Haaith end Menta tem 27 is marked other traumatic so	F	19e. Informant's Name/Raiationship (Typa, Pnnt)		19b. Maliing	Addrass (Stree	t end Numbar or Rural Rout			Stata, Zip Code)	
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ē,	f Haz f Haz othe		20a. Mathod of Disposition	20b. Pla	ca of Dispos	ition (Nema of etory or other pla	Dat	1		City or Town, S		
Ē	Daltimore, IVI permit. Peges 1 and 2 Department of Hasith e Important: If them 27 is sny Injury or other tra once.		1 M Burial 2 □ Cramation 3 □ Ramoval from 4 □ Donation 5 □ Othar (Spacify)	n Stata	*		·	26/99	TTMONI	TIM MAT	OVI AND	
alti			21. Signatura of Funaral Sarvica Licansaa 22. Name end Address of Facility									
מ	Depariment of the permit of th		SCHIMUNEK FUNERAL HOME OF BEL AIR, INC. 610 W. MACPHAIL ROAD, BEL AIR, MD. 21014									
			23a. Part1. Entar the disaasa, or complications that	causad the death.	Do not anta	tha moda of dy	ng, such as cardiac or rasp	BEL A	IR, MI		L4 oximeta	
1	Physician		shock, or heart failure. List only one cause on	aach lina.		,	7/2			Intan	ral Between t and Death	
	/Medical		Immediata Causa (Final diseasa or condition T VMDHOMA									
	Examiner		diseasa or condition e. LYMPHOMA rasulting in death) Due to (or as a consequence of):									
	₽ #	iner								1		
	cate be axecuted chysician and the burief-transit	Examine	Sequentially list conditions,	Due to (or	as a consequ	ence of):						
Š	e axe	Ē	Sequantially list conditions, if any, laeding to immediate cause. Entar Undarlying Causa (Disaasa or Injury									
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פס	es thet the death certific igned by the attending p be detached for use as	Physician/Me	u.							1		
ċ	the the	ysic	Part II. Other significant conditions contributing to	death but not rasult	ing in tha und	dartying ceusa gi	ven in Pert I. 2	3b. Did toba	cco uae con	tribute to the c	ause of death?	
ŗ	het ti ed by detac							1 🗆 Yes	2□ No	3 Probably	4X Unknown	
cords,	law requires thet the as been signed by th 2 should be detache	d by					20	le. Was an a	utonsv	24b. Wera au	opsy findings	
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5	th. After a funer	tio	1 X Naturel 5 ☐ Panding (Moi 2 ☐ Accident invastigation	nth, Day Year)	Injury		rk? ∣Yas 2∐No					
0	or Attending efter death. Director: After I in by the fune	E C	3 Suicida 6 Could not be determined 28a. Piac	e of injury - At hom	na, farm, strae	at, factory, office	office 28f. Location ((Street and Number or Rural Route Nur		e Number,	
5	s effe of in	Certification:	4 Homicida detarrimed build	ling, etc. (Specify)		·	Ci	ty or Town, S	rafa)			
	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funeral Director: After this cartific completaly filled in by the funeral director,	0.0	29a. Cartifiar (Check only 2 Medicat Examiner: On the letter of the let	a best of my knowi	edge, death	occurred at tha ti	ma, data and placa, and du	e to the ceus	a(s) end mer	nnar es steted.		
	in 24 he Fi	edicai	La medical Examination On the	pasis of axamination	n and/or inve	stigation, in my	opinion, daath occurred at t	ne time, date	and piece, e	end dua to the c	euse(s)	
1	2 5 6	Σ	29b. Signatura and titla of pertifiar			29c. Licans		29d.	29d. Data signed (Month, Day, Yea			
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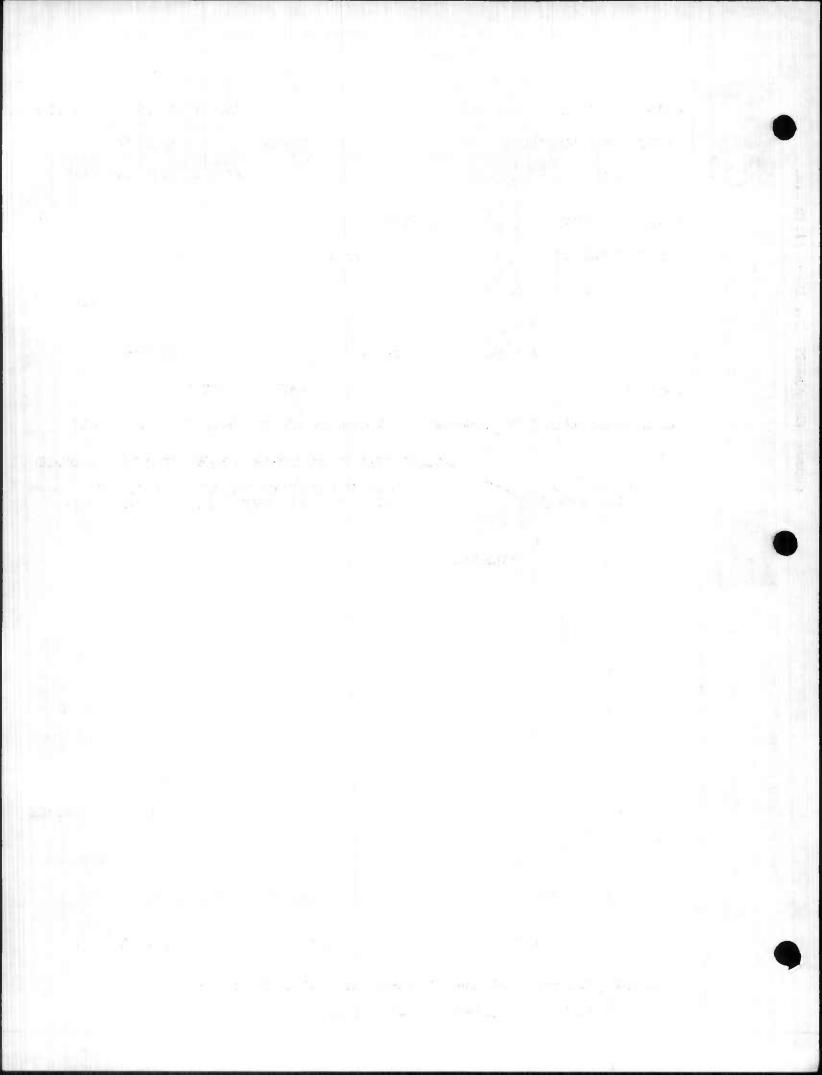
State Registrar

DR. TARIQ MAHMOOD - 2300 DULANEY VALLEY RD.

Data filed (Month Par Year) 1000 32. Radistrar's Signature 31. Data filed (Month Par Year) 1999

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

TIMONIUM, MD 21093



Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

D.

4a Facility Name (If not institution, give street end number)

ISAIAH

HUSPITAL CENTRE

7. Age (In yrs. last birthday) If Under 1 Year
Months Days FRAKKLIN SOUARE Hours | Min. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 8 Sex **Funeral** 180M 20 F 219-28-0699 65 Director 6 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location "natural", or items 23a or 28a-f ahow edical Examiner must be notified at Director MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 8413 MERRYMOUNT DRIVE 21244 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 52/56 1 ☐ Never Married ZXMarried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) PASTOR 12yrs 2vrs 17. Father's Name (First, Middle, Last) 8 Pages 1 and 2 should be 1 ant of Health and Mental SOLOMON K HILL SALLY ANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If frem 27 is any Injury or other trau Ernestine Hill/Wife 8413 Merrymount Drive, Baltimore Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 14 Burial 2 Cremation 3 Removal Irom State 4 Donation 5 Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Light 22. Name and Address of Facility 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. CORONARY ARTERY DISEASE

Due to (or as a consequence of): Examiner Examine sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, by The law requires 24a. Was an autopsy parformed? Completed of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DoNatural 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendition within 24 hours after death.

To the Puneral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9000 NOVELLO NOKA 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 22. 1999 AUGUST 1:08 PM 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE ALTIMORE Birthplace (Steta or Foreign Country) MARYLAND 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14 Race - American Indian Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry MINISTRY 18. Mother's Name (First, Middle, Meiden Sumeme) BRIGGS 20c. Location - City or Town, State 8-27-99 OWINGS MILLS, MARYLAND WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Approximate Interval Between Onset and Death

YEARS

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24b. Were autopsy lindings available prior to

completion of cause of death?

1 Yes 20 No

1 Yas 2 No

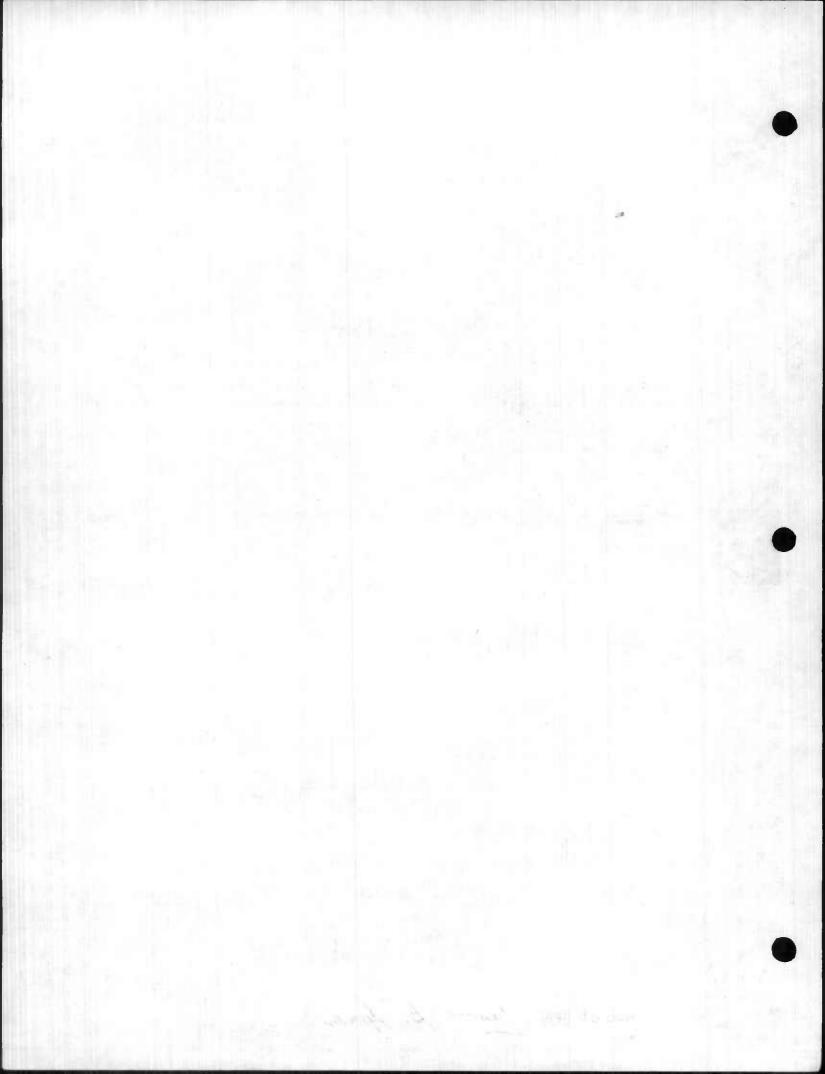
29d. Date signed (Month, Dey, Year)

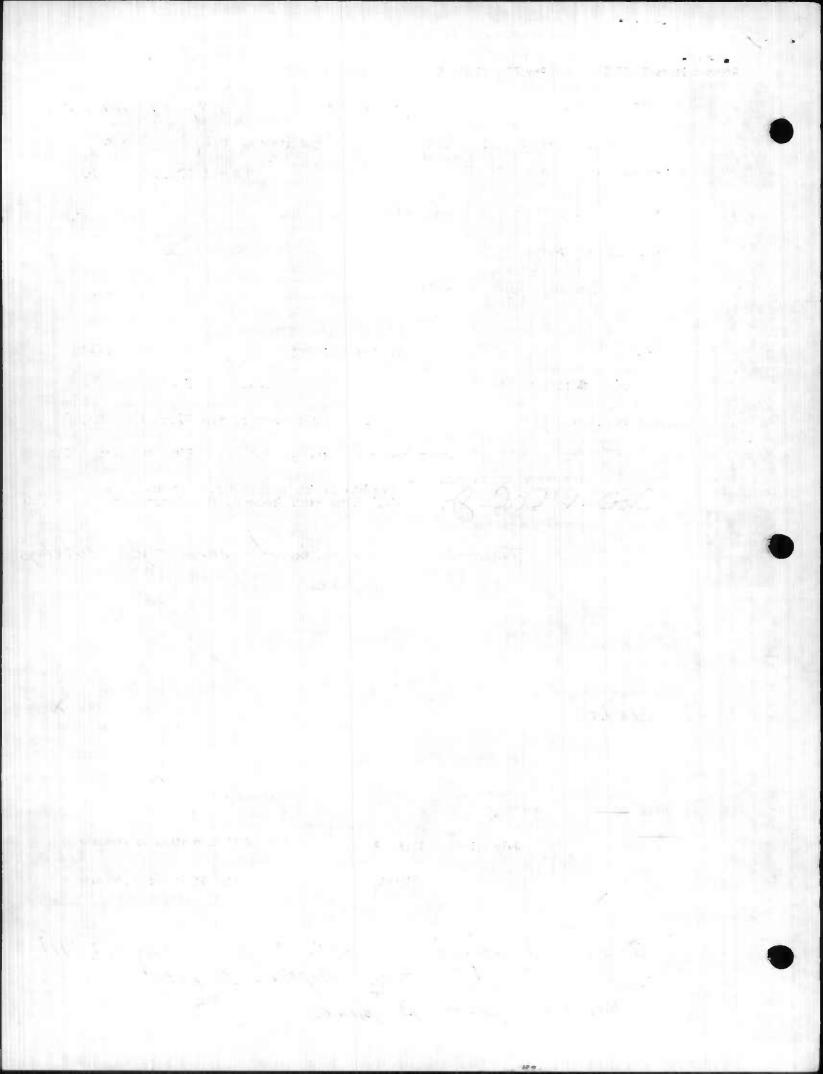
FRANKLIN SO. DR. BALTO, ND

Certificate of Death

AUG 26 1999

DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

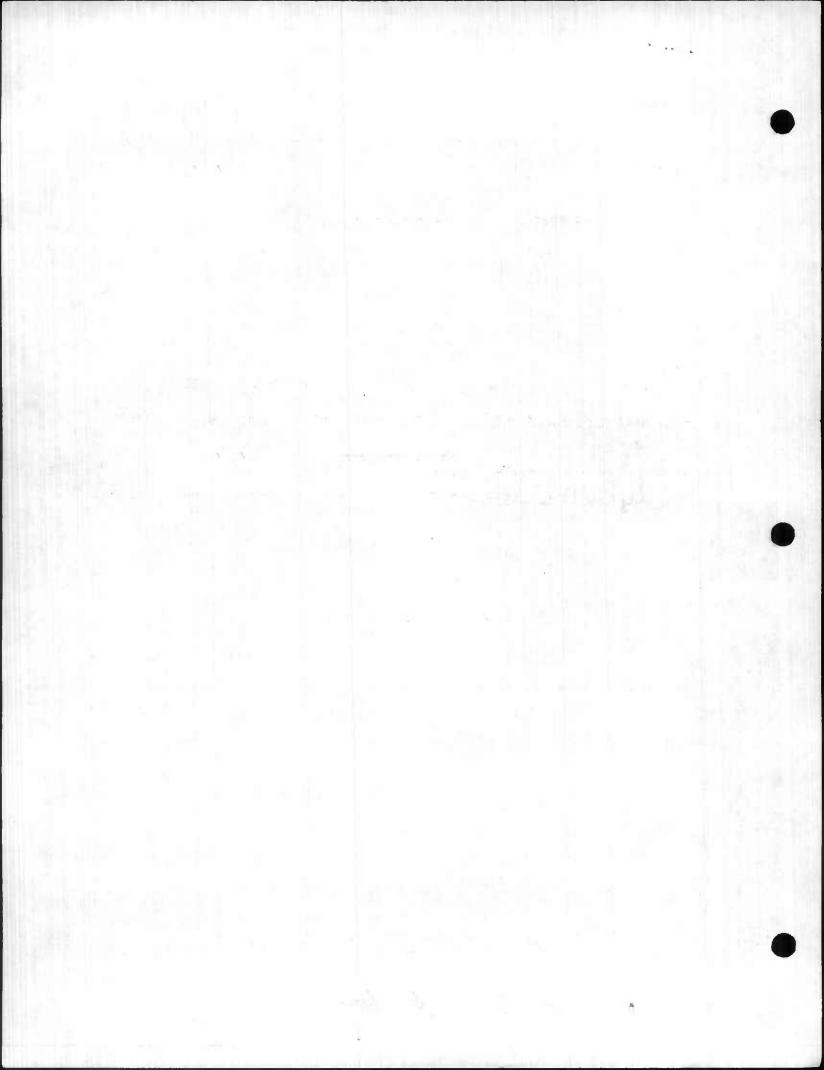
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 1999 HODG-SON AUGUST GARY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE Hospital fookius 6. Sex JOHNS If Under 1 Year If Under 24 Hrs. 7. Age (In yes. last birthday) Birthplace (Stata or Foraign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Houra XXM 2 F Yrs. 05/13/1955 Director 538-60-4777 Washington 44 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-7 show 1 Yes 2 No Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 Berrs 23a 755 Dustin Drive United States Funeral 17601 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Never Married 2 Married b altimore, Maryland 21215-0020 1 Tes 2 XXX Specify: Specify: White "netural", 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Hygiene. Eiementary/Secondary (0-12) Collega (1-4or 5+) Air Conditioning 12 Repairman permit. Pages 1 and 2 should be fit. Department of Health and Mental Hy. Important if New 27 is marked any Injury or 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 2 V. Virginia Hallett Howard Hodgson 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 755 Dustin Drive Mrs. Marie Hodgson / Wife Lancaster, PA 17601 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) Evans Crematory 08/24/99 Leola, PA 21. Signature of Funera Service License Leginen D. Coster 22. Nama and Addrasa of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part. Enterthe disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final WEEKS disease or condition resulting in death) Examiner Examiner ARY LEAK The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) TRANSPLANI Box 68760 Physician/Medical Due to (or as a consequence of) MONTHS DUE TO HEPATITIS ALLIRF P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 20 No 3 Probably 4 Unknown Renal ACUTE Fallure Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: Atter this certifica Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner atated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certified 29c. License number 6/anda -000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 600 NORTH WOLFE STREET BALTIMORE MD 21287-JOLANDA ZICKMANN

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year) AUG 2 6 1999

32 Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 26760 Certificate of Death AMEND #10e PER F.H. G774 8-31-99 J.A 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 26, AUGUST 3: JUKNELIS CATHERINE /Medical 4a Facility Name (If not institution, giva street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALLIMORE CITY
If Under 24 Hrs. 8. Dete of Blan NOSDITAL SOMNS HODKINS 8. Dete of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1□M 2□F 217-64-6956 46 Director FEB Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Massical Examinar must be notified at 1 Yas 2 No Catonsville MD Baltimore Director 10e, Street and Number 10f. Zio Code 10g. Citizen of What Country? 1201 BIDDLE PLACE 21228 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Merital Stelus Bleck, White, etc. filed within 72 hours after 1 ☐ Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 Pages 1 and 2 should be filled within sent of Health and Mental Hygiene. nt: If them 27 fa marked other than iry or other traumatic avent, the Menty College (1-4or 5+) Medical Assistant Physician's Office Baitimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) Be Max Randolph Mary Jane McNeff 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) James A. Juknelis/husband 1201 Biddle Place Catonsville, MD 2
Data 20c. Location - City or Town, State 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) permit. Pages Department of Important: If It any Injury or on once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Metro Crematory, Inc. 08/26/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Puneral Service License 22. Name end Address of Fecility devarl A. Cremation Society of Maryland, Inc. Edward A. Gredbrchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical UREMIA 3 days Examiner Due to (or as a consequence of): Examiner HEPATORENAL SYNDROME 2 WEEKS that the death certificate be assecuted physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. ALCOHOLIC CLRRMOSIS 5 YEARS Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) 980 ò P.O. Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown signed t Records, ģ The law requires 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24e. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funaral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? Affer Division or Attending 1 X Netural 5 Pending investigation 24 hours efter death.

Funeral Director: Af 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier RES - 000 and E august 26, 1799 0 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID & KAKLAN, MO; 600 N WOLFE ST. TOWER 110; BACTIMORE MD 21287

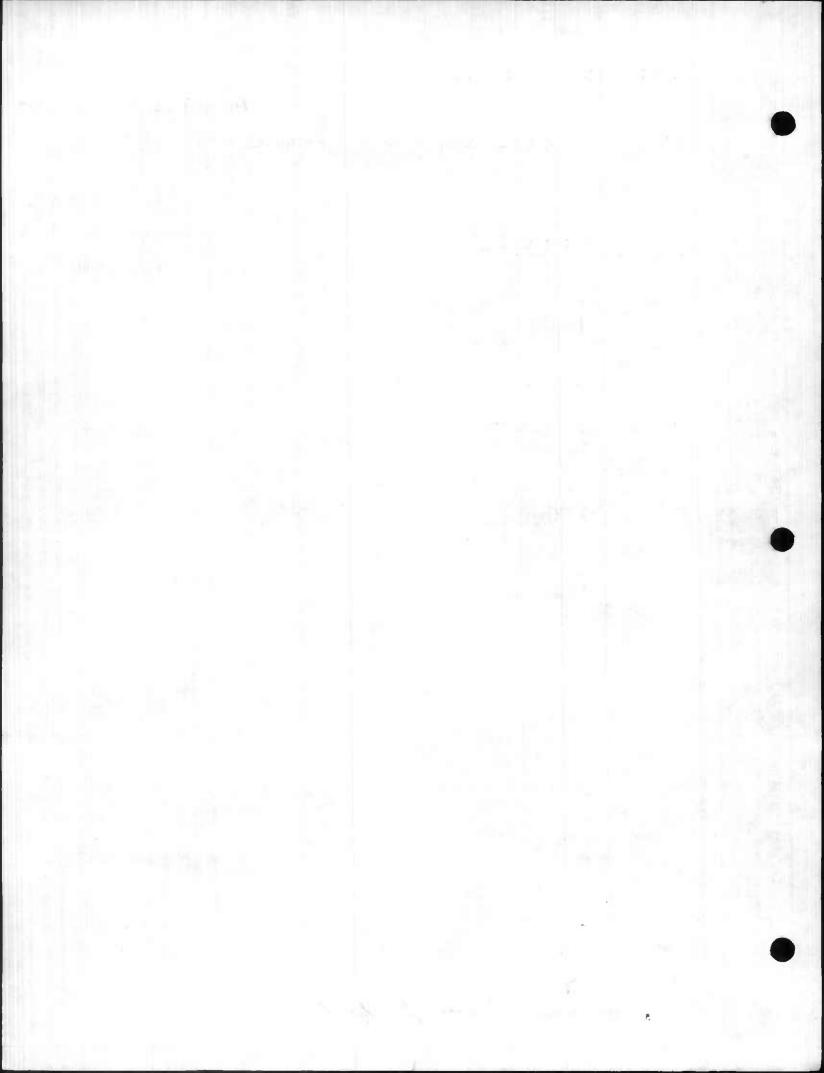
State Registrar

31. Date filed (Month, Day, Year) AUG 26 1999 32. Registrar's Signature

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Amn a



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month O 8 Johnson-Anderson 7:45 AM Diamond 4e. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown If Under 24 Hrs. 8. Date of #101 Balto. Dramble ane If Under 1 Year 8. Date of Birth Month, Day, Oct-23 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex 217-45-4598 1□M 2DF Months Days Hours Min Usual Residence of Decadent 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Randa 1 Yes 2 THO Daltimore S Town 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 21133 and 10 12. Was Decedant Evar In U.S. Armed Forcas? 1 ☐ Yas 2 Û No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 11. Marital Stetus 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced Blac 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surname) EVSOV Say Ind andida ohnson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Rendallstown, MD 21133
Data 20c. Location - City or Town, State randida 20b. Placa of Disposition (Name of cametery, cramatory or other placa) 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 8/26/99 Kandallstown, Mi 4 ☐ Donation 5 ☐ Othar (Specify) Tars 21. Signature Punaral Sarvica Licensea 22. Name end Addrass of Facility Cary P. March Funeval Horny plar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Bulto, SMD 21229 Approximate Intarval Batween Onset and Death Immadiata Causa (Final Hypoxia, pulmonary
Due to (or as a consequence of): disaase or condition resulting in death) Drevmonia Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarlying Cause (Diseasa or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of): lung disease Chronic Dua to (or as a consequence of): Chronic aspiration Preumonia Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? to trive, steroid 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Were autopsy findings evailable prior to icthyosis of the skin, developmental completion of causa of death? delay 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Aasidanca 6 Other (Specify) 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

Physician /Medicai Examiner

Baltimore, Maryland 21215-0020

Hygiene.

Pages 1 end 2 should be filed vent of Health end Mental Hygie ant: If item 27 is marked other?

permit. Pages 1 end 2:
Depertment of Health er
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

Director

by

Completed

Funeral

Director

physician and s the burial-tran certificete

Physician/Medical Be Completed by

Records, P.O. Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

> State Registrar

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4 Homicida

31. Data filed (Month)

29b. Signatura end titla of captilial

29a. Certifier

platad cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave, Balt Md ZIZIS MD

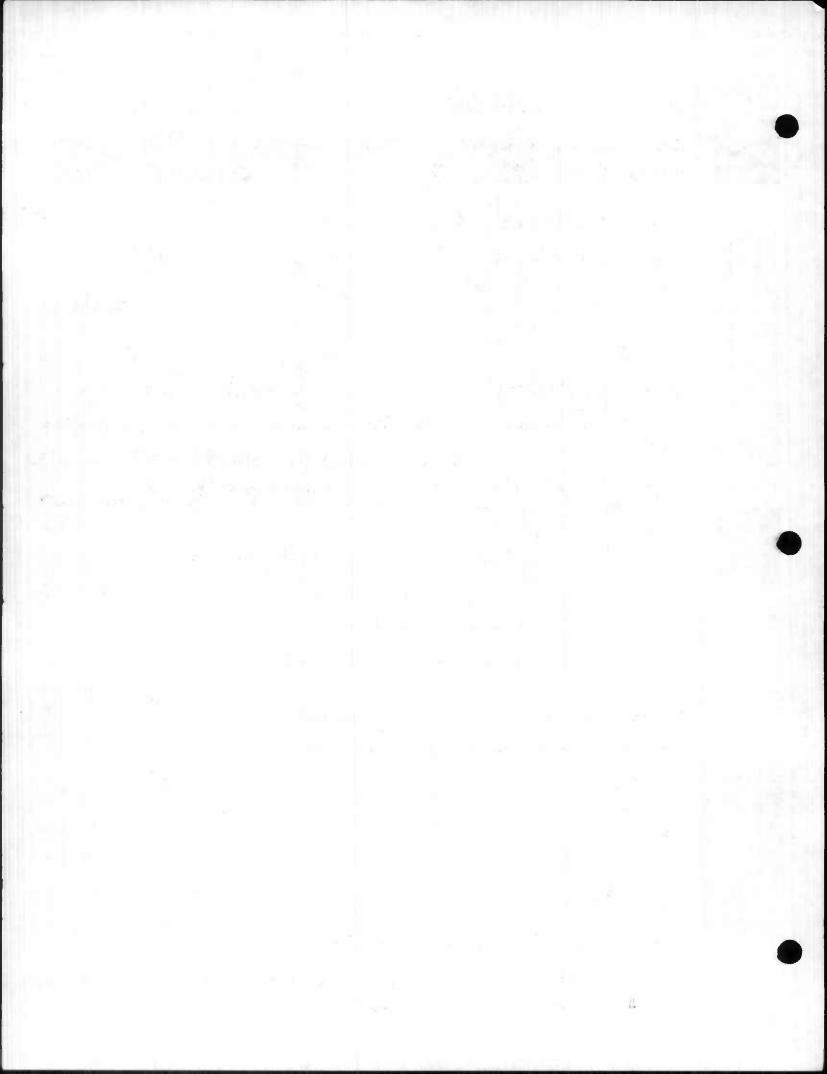
1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Dete signed (Month, Day, Year)

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Tima of Death Month 9.53 AM Anna M. Kneavel 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death St. Elizabeth Nursing Home Baltimore N/a If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1 □ M 2 🛛 F Months Days Hours Min Yrs. 95 215-07-1143 Aug. 4, 1904 Maryland Usual Rasidance of Dacedan 10a Stata 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4037 Wilkens Avenue, 21229 USA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Reca - American Indian, 12. Was Decedent Ever in U,S. Armed Forcas? 11. Maritel Status Black, Whita, atc. 1 ☐ Yes 2 No 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 8 0 Binder Business Form Co. 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fether's Name (First, Middle, Last) George W. Stallings Sarah Richard 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stafa, Zip Coda) Roxie L. Atkinson / Personal Rep. 4037 Wilkens Avenue, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State Metro Crematory 8/24 Baltimore, Maryland 22. Nama and Addrass of Facility of Fusional Service License Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Entar tha disaase, or complications that ceusad tha daath. Do not enter tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina. Approximate Intarval Batween Onset end Deeth Immediata Causa (Final Varkinson's diseesa or condition rasulting in death) detseas lears Dua to (or as a consequance of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Urinary tract intection 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ToTut discuse Degenerative 1 Yas 2 No 1 Yes 2 No

Physician /Medical Examined

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P.O.

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Division of Vital

Physician

/Medical

Examiner

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7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Modical Examiner must be notified at

12 should be filed within 72 hours after n end Mentel Hygiene. Is marked other than "natural", or its

permit. Pages 1 and 2.
Department of Haalth el Important: If Item 27 is any injury or other traus

the Maryland

Examiner physician and the buriel-transit Physician/Medical ed by the a signed t by peen

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Certification:

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Hospital or Attanding 24 hours after death. Funeral Director: After

24 hours a

To the Within 2

funeral

25. Was cesa refarred to medical axaminar?

1 TYas 2 LAN

27. Mannar of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicida

26. Piaca of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Yas 2 No

6 ☐ Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 👺 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and piace, and due to tha cause(s) and mannar as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d, Deta signed (Month, Dav. Year)

29b. Signature and titia of certifiar

5 Panding investigation

D52544

30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print)

5. Lee 500 N. Pollting Road, Suite 4, Catonsville, UND 21228 Benjamin M.D. 31. Deta lied (Month, Dey, Year) 32 Registrar's Signatura

State Registrar

Medical

DHMH 16 Rsv 6/95

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, Koerner Irvin Leonard 1:45 PM August /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore Franklin Square Hospital Center 6. Sex 10 M 2 F If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 212-05-4082 84 YES. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore. Baltimore 1 Yes 2 No Maryland Director 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? matther U.S.A. 8800 Walther Blvd., Apt. 3616 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after earl of Health and Mental Hogisms.
Int. if Ren 37 is marked other than "natural", or its ury or other traumatic event, the Medical Examine 1 Never Married 2 Married ☐ Yes 2 (No Yes, Give Baitimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: Specify: White ğ 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Gas & Electric Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Utility Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Marie Lergenmiller George Koerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd., Apt. 3616, Balt., MD 21234 Mrs. Agnes A. Koerner (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 8/26/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD - Mais C 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Sudden myacardial disease or condition resulting in death) Examiner es a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) signed by the attending p 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 ☐ Yas 2 No this certificate funeral director, Be 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ TVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred After Natural 5 Pending Investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide n 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier completaly (Check only one) To the the the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and fitte of certifie 10 my & Ores 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

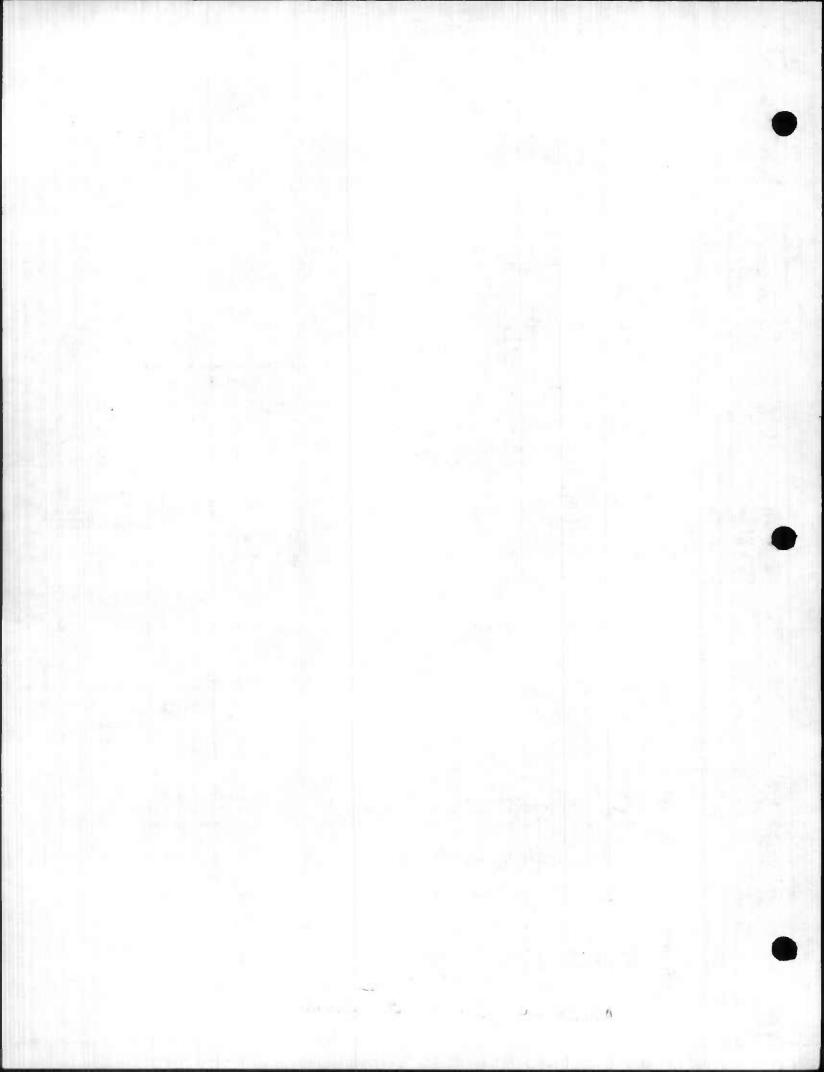
Georgelic we as 7672 Belg B9/Hours, mb 21236 32. Registrar's Signeture 31. Date tiled (Month, Dey, Year)

DHMH 16 Rev 6/95

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State Registrar

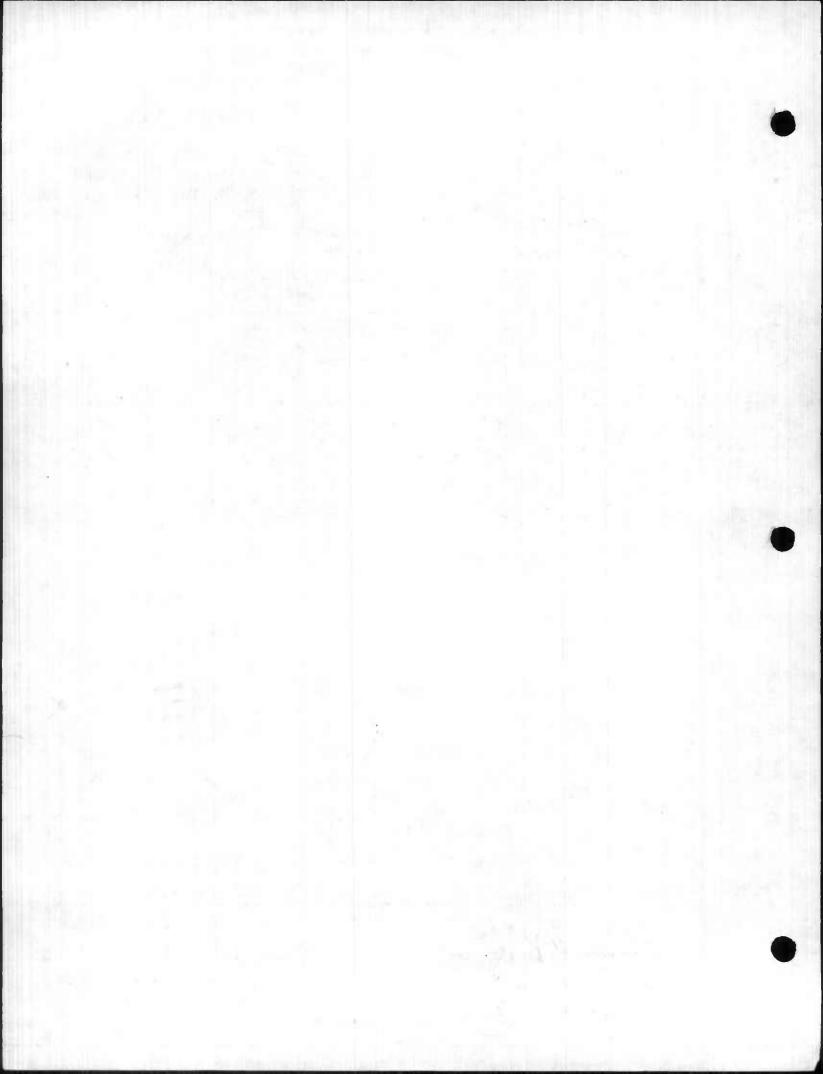
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32 Registrer's Signeture

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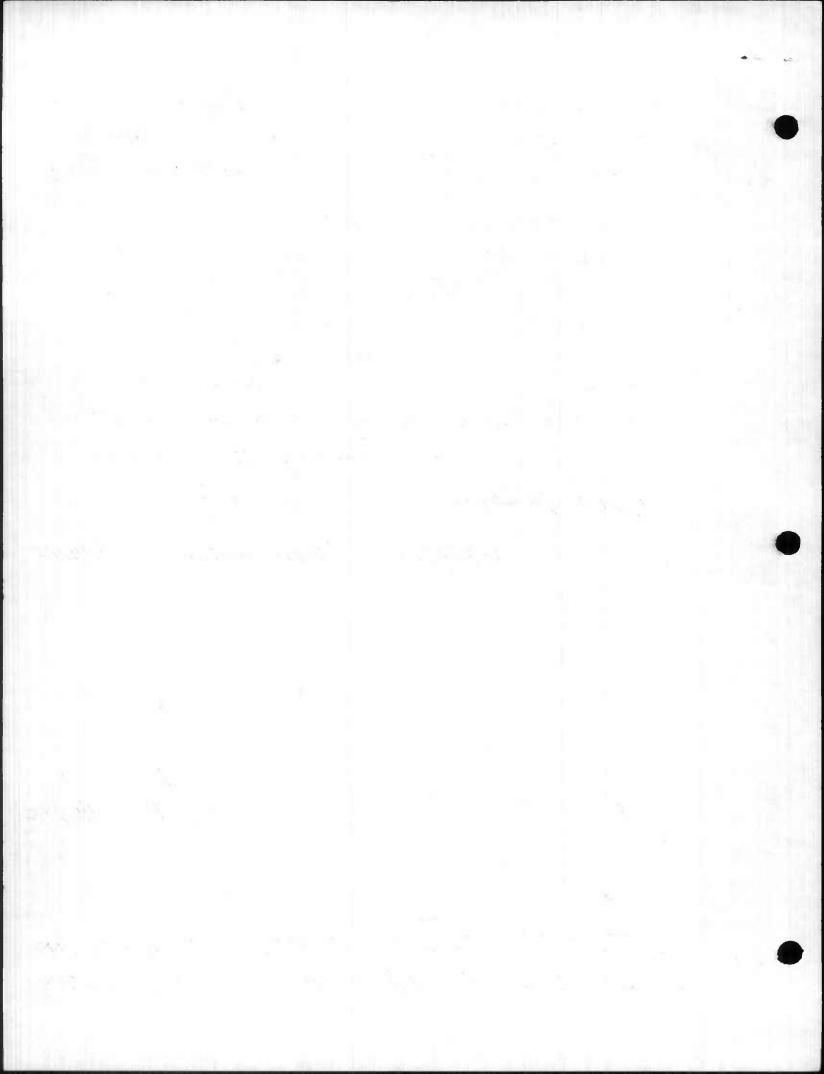
111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26765

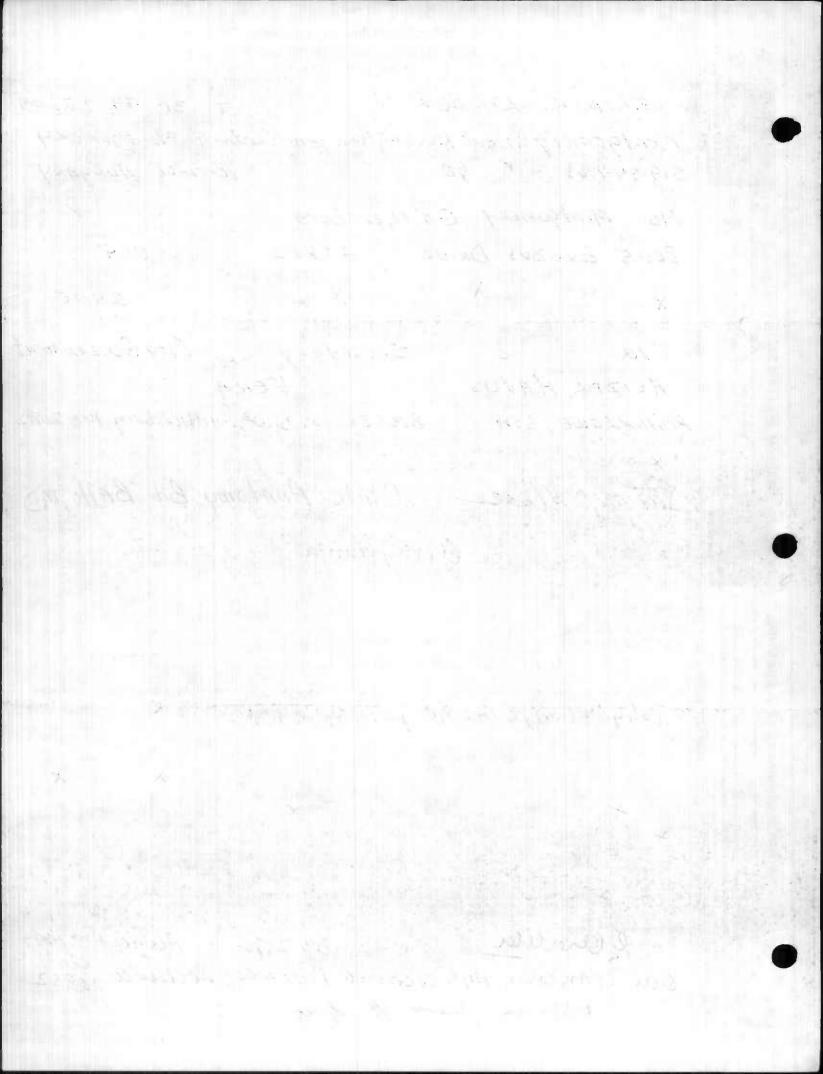
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/Medical Examiner		Booker Thomas Lawton 4e. Fecility Neme (If not institution, give street end number) Chesapeake Hospice							wn, or Lo	August	20, 1999 14c. County of Deeth		
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Maryland -f ehow	tor	Usuel Residence of Decedent 10a. Steta 10b. Con		10c. Cit	y, Town or Lo	cation Annap	oli	S				1	10d. Inside City Limits
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Dallimore, permit. Pages 1 e Department of Hee Important: If Nem: any Injury or othe		21. Signature of Funeral Service Licenses 22. Nama and Addre						Vet Cem 8/27/99 Owings Mills, Md.					
Physician /Medical Examiner	Jer.	23a. Part. Enter the disease shock, or heart feilure. Immediate Cause (Finat disease or condition resulting in death)	e, or complications the List only one cause or e.	META		ar the mode	of dyir	ng, such as	cardiac (est,		Approximete Intervel Between Onsat end Deeth 3 4 FARS
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The Hospital or Attending Physical Advanced Britanger Attending Physical A hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Co	astigation uld not be	ce of Injury - At hi	Injury ome, ferm, sfre y)	М	1 🗆	Yes 2□t	-	28f. Location (St City or Town		ber or Run	al Route Number,
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Day Pegs.

		,	Certificate of	of Death	Re	eg. No.	20100		
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/Medical Examiner	4a Facility Name (If not institution, give s	ocation of Death	urg Montgomery						
Funeral Director	5. Social Security Number 6. Say 529-54-9763	8. Date of Birth (Month, Day,	8. Dete of Birth (Month, Day, Year) 9. Birthplace (Country) 9. Country) 9. Birthplace (Country) 9. Bir						
Within 72 hours efter death with the Manjand Jwithin 72 hours efter death with the Manjand Jene. Jene. The Mod rai Examiner must be instilled at completed by Funeral Director.	Mb Montgo		Town or Location FITHERSE	ourg		10d. Inside City Limit			
	10e. Street and Number 8005 EX62	ous DRIVE	10f. Zip Cod	0882	11	Og. Citizen of W	hat Country?		
or, or items	3 Widowed 4 □ Divorced	12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yaar or Dates:	13. Was Decedent If Yes, specify C	of Hispanic Origin? (Sp cuban, Mexican, Puerto No Specify:	ecify Yas or No- Rican, atc.)		- Amarican Indian, , White, etc.		
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ages ent of rt: If it	20a. Mathod of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	CONT	ce of Disposition (Name of netery, crematory or other		Data	20c. Location - C	Cit∮ or Town, Stata		
Physician /Medical	23. Part1. Enter the chease, or compliance, or heart fallure. List only or	/ -	d., BAHO. MD Approximate Interval Between Onsat and Death						
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BOX 68 / 60, seth certificate be executed ettending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
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5 2 8 G					perform		completion of causa of death?		
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To the Hospital or Aff within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) Certifying Phys	sician: To the best of my knowled ner: On the basis of examination and manner stated.	edge, death occurred et th n and/or investigation, in n	e time, date and place, ny opinion, death occur	and due to the ci red at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)		
To the within To the comp	29b. Signatura and titla of certifier	ela	29c. Llo	ense number B4757	8 2	9d. Data signed Augu	(Month, Day, Yaar)	2/	
	30. Name end address of person who co	mpleted cause of death (Item 2	3a) (Type, Print) VCfCVPLLE	Pitce # 4	101, RO	cour	le 20852		

State Registrar



99-4954-510 Please Type or Print in Biack Indelibie ink. Assure Aii Copies Are Legible. MHL FRED State of Maryland / Department of Health and Mental Hygiene LAWS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death AUGUST 22% **Physician** 199^{kgar} 00:15 AM Fred Laws /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner BON SECOUR HOSPITAL BALTIMORE If Under 1 Yeer Months Days 5. Sociel Security Number 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 248-52-4950 64 11/19/1934 South Carolina Usual Residence of Deceden the Maryland 10a. Stete 10b. County 10d. Inside City Limits ahow 10c. City. Town or Location "naturel", or items 23s or 28s-f show 1 Ves 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 35 S. Fulton Avenue 21223 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Heelih and Mentel hygiene.
art: if ferm 27 is marked other than "naturel; or itse iny or other traumfic event, in the contract of the inentel or or other traumfic event, in the contract of the inentel or or other traumfic event, in the contract of the inentel or or other traumfic event, in the contract or or other traumficers. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black p 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) 6 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Junius Laws Lillian Boone 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 S. Fulton Ave., Baltimore, Maryland 21223 ce of Disposition (Neme of Date 20c. Location - City of Town, State Delores Laws / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Department of Important: If he eny injury or o 1X Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete Prospect Hill Cemetery 08/28/99 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility The Derrick C. Jones Funeral Hm. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that a used the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, ahock, or heart failure. List only one ceuse on each line. Approximate intervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Final ATHORNOS CUMO FU CAMPIO VASCUME PLATOST disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner iclan and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Last Due to (or as a consequence of) physician the buria Physician/Medical Due to (or es a consequence of): 8 030 been signed by the a should be detached t Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? MO-EUN page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: funeral director. Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 Watural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. P.O. Records, Division of Vital

filled in by # Funeral to the Hospital edical À within 2 To the F complet State Registrar

31. Dete fited (Month, Dey, Year)

4 Homicide

(Check only one)

29b. Signature and title of certifier

29e. Certifier

KOREL M

OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Dete signed (Month, Dey, Year) AUGUST 22, 1999

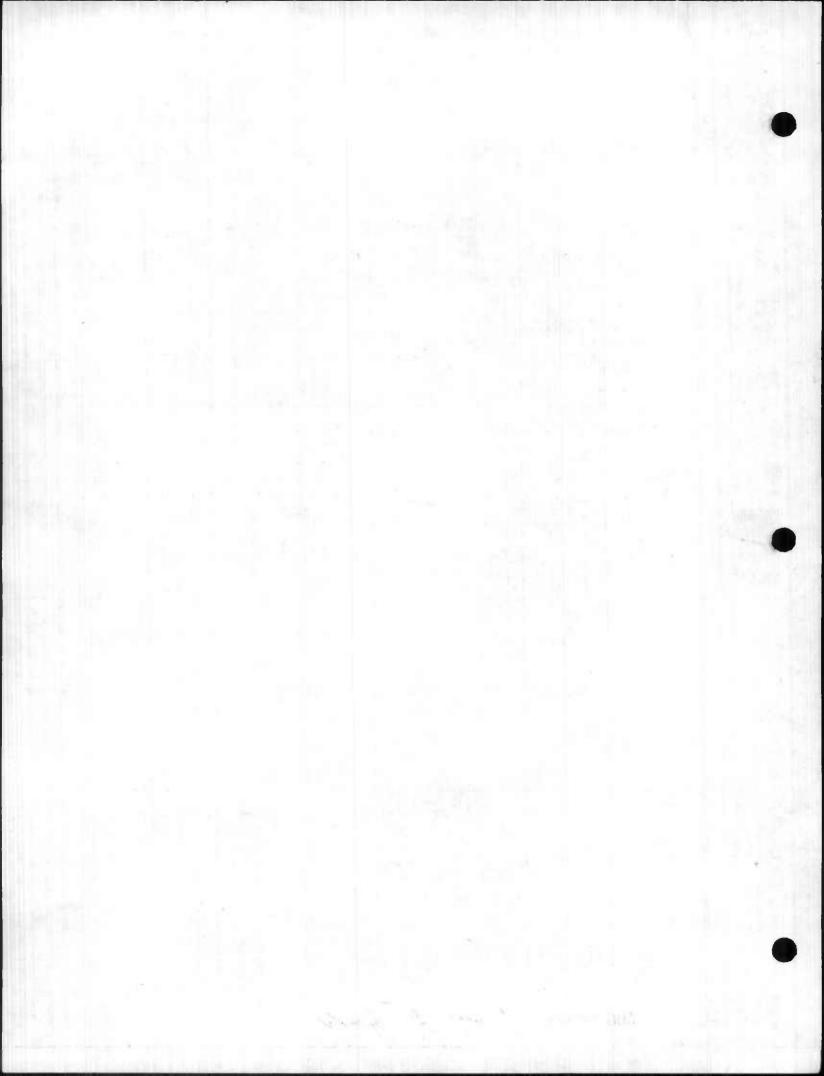
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MARYDOM 111 Penn Street, Baltimore, Maryland 21201

AUG 26 1999

32. Registrer's Signeture

DHMH 16 Rev 6/95



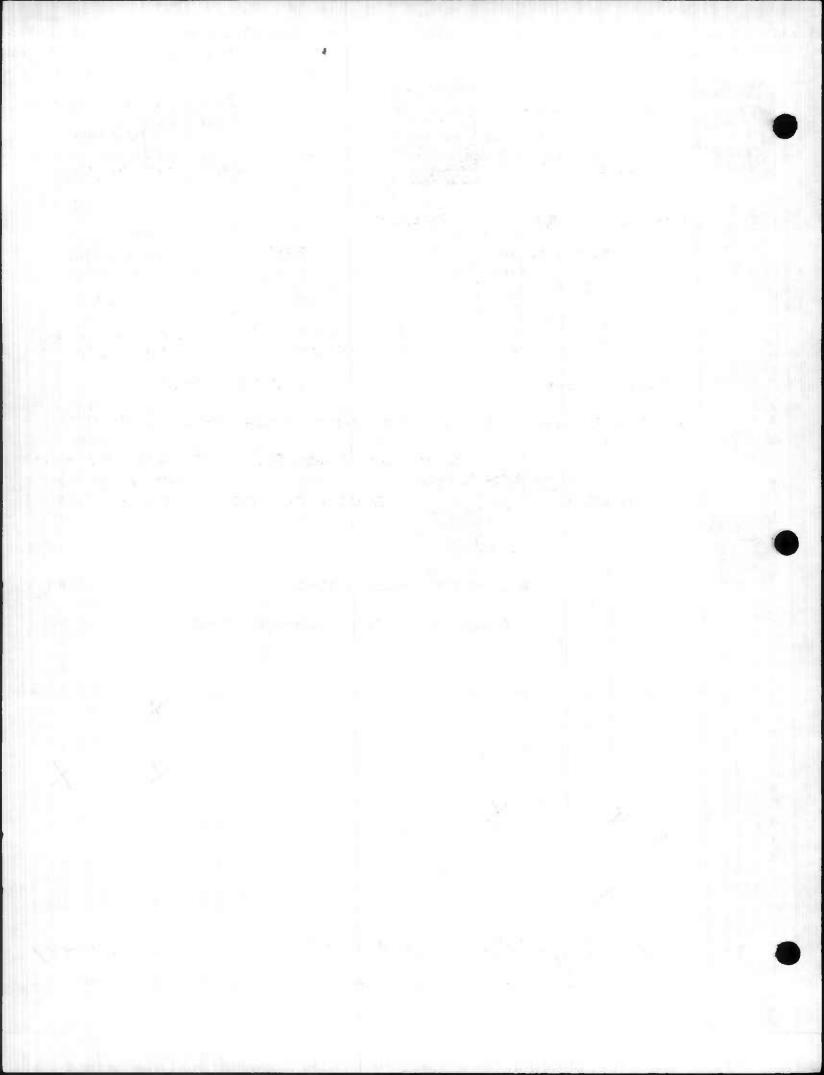
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Date of Death Day 4, 1999 **Physician** AUGUST 08:55 PM JOHN LAGNA /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 6. Sex 1 M M 2 ☐ F If Under 1 Year | If Under 24 Hrs 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Hours 212-05-4962 92 **Yrs** 1907 Director Maryland Usuel Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location Od. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified all XXVas 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21206 4701 Mannasota Avenue United States death Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health end Mental Hygiene. Introcrant: If Item 27 is marked other than "natural", or flen any Injury or other traumatic avant 1 Nevar Married 2 Married 1□Yas 2XNo Baltimore, Maryland 21215-0020 þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Baltimore Gas and Elamantary/Secondery (0-12) Collega (1-4or 5+) Accountant Electric Co. 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Palmira Fassio Frank Lagna 19a. Informant's Neme/Ratationship (Typa, Print) 19b. Mailing Address (Straet end Numbar or Rural Routa Number, City or Town, State, Zip Coda) Mrs. Rose M. Lagna (Wife) 4701 Mannasota Avenue Baltimore, MD 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Buriel 2 Cramation 3 Ramoval from State Sacred Heart of Jesus Cem. 8/27/99 4 □ Donation 5 □ Othar (Specify) Baltimore, Maryland 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Feclity Michael E. Canapp 5305 Harford Road LEONARD J. RUCK, INC. Baltimore. MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Intarval Batween **Physician** /Medical Immediata Causa (Finat PNEUMONIA 2 WEEKS disaasa or condition rasulting in death) Examiner Dua to (or es e consequence of): Examiner RESPIRATORY INSUFFICIENCY YEARS buriel-transit Sequentially list conditions, if eny, laading to immadiata causa. Entar Undarfying Causa (Diseasa or injury that initiated avants rasulting in death) Last and Dua to (or as a consequence of): physician a the buriel Box 68760. CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Physician/Medical Due to (or as a consequence of) ettending esn ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by ti 2000 1 ☐ Yes 3 Probably 4 Unknown þ 24e. Was an eutopsy performad? 24b. Wara autopsy findings aveilable prior to completion of cause of death? Completed peen page 2 hes this certificate Division of Vital Hospital or Attending Physician: 7 24 hours effer death. Funeral Director: After this certifica 25. Was case refarred to medical axaminar? Be 26. Pleca of Deeth (Check only ona) 1 L Inpatient Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No To 2 ER/Outpatient 3 DOA funeral 27. Marinar of Death 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 5 Panding 1 ☐ Yas 2 ☐ No 2 Accidant Invastigation 6 Could not be determined 3 ☐ Suicida 28a. Place of injury - At homa, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) in by 4 Homicida To the Funeral Disconnected filled in Cartifying Physician: To the bast of my knowladga, death occurred at the time, dete end place, end dua to the ceuse(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. 29a. Certifian Medical (Check only one) ğ 29b. Signatura end titla of certifian 29d. Data signed (Month, Day, Year) 29c. Licansa numbar 16492 30. Nema and eddress of person into completed cause of death (Item 23e) (Type, Print) M. D., BEATRIZ P. DIZON, 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State AUG 2 6 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

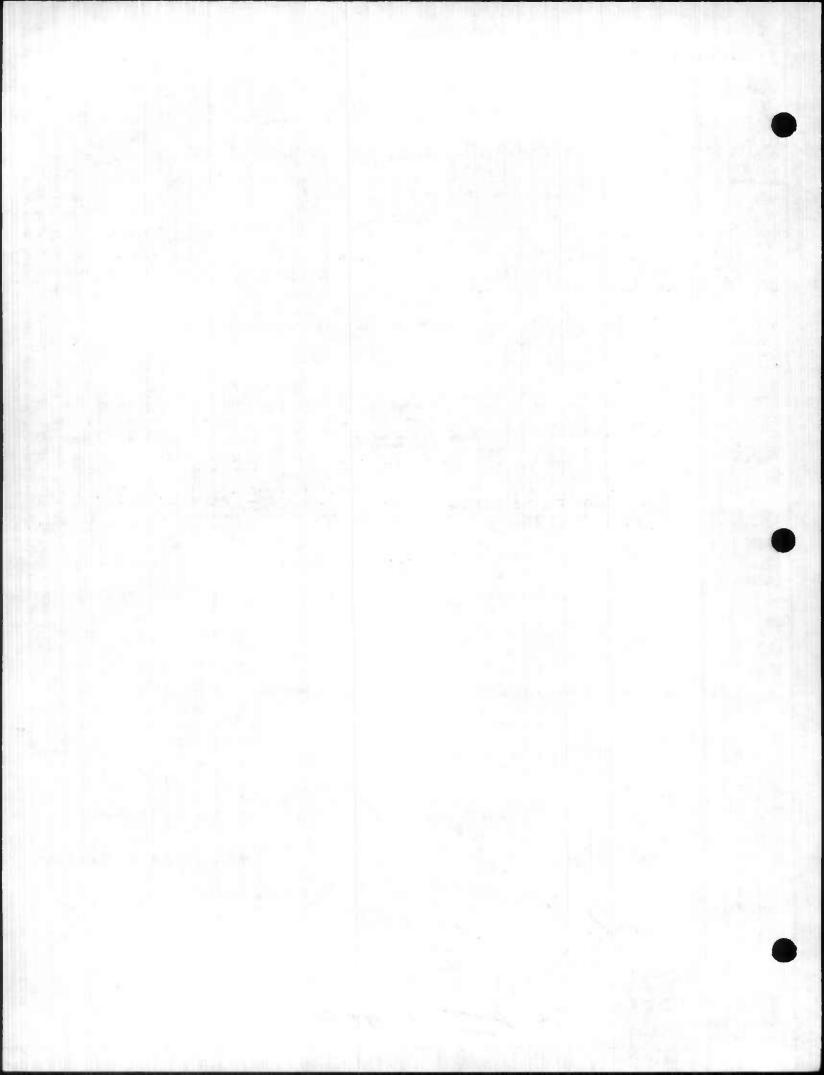
State of Maryland / Department of Health and Mental Hygiene

ELIZABETH M. MILLER Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month **Physician** 1500PM Elizabeth Miller M. AUGUST 19, 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1409 DEER PARK ROAD FINKSBURG CARROLL Munder 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 9. Birthpiace (Stete or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** Days 1□M 2♥F Months Yrs. Director 215-05-6976 82 January14,1917 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Carrol1 Finksburg 28a-f 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 there 23a or 1409 Deer Park Road 21048 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married à 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 € Widowed 4 Divorced natural. Hygiene, other than "naturn ent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Unknown College (1-4or 5+) Factory Worker Stove Company Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 ahould be till ment of Health and Mental H ant; if them 27 is marked oth lury or other traumatic even Be Wendel Besser Amelia Koch 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Harman/Friend Baltimore, Maryland 21229 623 S. Warwick Road 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date Department of Important: If It any Injury or o 15 Burial 2 □ Cremation 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) 8/24/99 New Cathedral Cemetery Baltimore, Maryland 21. Signet@e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 uanita thomas 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical a Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): USB BS igned by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 INSPECTION has 1□Yes ZXNo certificate 1 ☐ Yes 2 ♥ No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Certification: To XXYes 2 No this funaral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 (X) Yaturat 5 Pending s efter death. 1 Yes 2 No Investigetion 2 Accidant filled in by the 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homlcide 24 hours edicai 29a. Certifier 1 Certifying Physicians 7 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Exag of the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and menner stated. within 2 To the ŝ 29b. Signature and un 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. AUGUST 19, 1999 97 30. Neme and and on who completed ceuse of death (Item 23a) (Type, Print) 5 M/A C E K111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signetura State

DHMH 16 Ray 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Honth Uth 11:26 pm clor 4a Facility Name (If not institution, give at and number 4b. City, Town, or Location of Deeth 4d. County of Death BALTIMORE N/A Ta If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 05-10-15 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Deys Months Hours 218-05-5746 84 Yrs. BALTIMORE **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 BELAIR ROAD 21213 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, atc. 1 Yes 2 No 1 Never Married 2 Merried 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 11th HOUSEKEEPING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ELIZABETH DAY UNKNOWN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1100 STODDARD CT, BALTIMORE, MD 21201 WILHERMIA MOORE, DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other p Dete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removet from State MOUNT AUBURN 8-28-99 BALTO. MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth CEREBROVASCULAR ACCIDENT Immediata Cause (Final disease or condition resulting in death) Due to (or es a consequence of): HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown OBESITY 24b. Wera autopsy findings available prior to 24e. Was en autopsy completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Physician /Medical Examiner

requires that the death certificate be axecuted

WB

Box 68760.

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Division of Vital Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be flied v nert of Health and Mental Hygis int: If Nem 27 is marked other 1

important: if Nem 27 is m any injury or other trainings.

must be notified at

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filed within 72 hours after

altimore, Maryland 21215-0020

Examiner

physician and s the burial-transit Physician/Medicai for usa as 158 Certification: To funeral

1 Yes 2 No 27. Manner of Death Netural 2 Aceident

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-rai Director: A'
- n by thr within 24 hours aft To the Funeral Dis completely filled in Medical

Affer

death.

Hospital

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State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person who op

Mac

28a. Date of Injury (Month, Day Year)

5 Pending

mon

investigetion 6 Could not be

32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28h Tima of

28c. Injury at Work?

to carrying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated and death occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

AUG 2 o page - Source - Source

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Day Year 8,00 A.M. ar 4b. City, Town, or Location of Death 23, 1999 4c. County of Death 4s Facility Name (If not institution, give street and number) 3409 41/ton Baltimore If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1)X M 2□ F Yrs 219-01-0025 19 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 XYes 2 No NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3409 North Hilton Road U . S . A . 14. Race - American Indian, Black, Whita, atc. 21215 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Black 1□ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unknown Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) McKinley Monroe Juanita Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred Brown-Friend 3409 North Hilton Rd., Baltimore Md 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 22. Name and Address of Facility 8/28/99 Baltimore, Md of Funeral Service Licenses March F/H West unt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Hd 21215 hock, or heart failure. List only one cause on each line. Intarvat Between Onsat and Death Immediate Cause (Final Digbetic mellitus disease or condition resulting in death) Due to (or as a consequence of): gracery disease corongr Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Vascular Alsease peripheral Due to (or as a consequence of): teogrammitis Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /filedical Examiner

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we Hospital or Attending in 24 hours after death. we Funeral Director: Alte

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r than "natural", or hama 23a or 28a-f ehow the Medical Examinar must be notified at

I Hygiene.

permit. Pages 1 and 2 should be filled wit Department of Health and Mental Physieru Important: if item 27 is marked other tha any injury or other traumatic event, that

with the Maryland

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

physician a the burla signed by 1 Certification:

Physician/Medical þ Completed e a 2

25. Was case referred to medical assaminer? 1 Yes 20€No

5 ☐ Pending investigation

6 ☐ Could not be

28a. Data of Injury (Month, Day Year)

28b. Tima of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

1 Schatural 2 Accident

3 Suicide

4 Homicide

the Constyling Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and mennar as stated. ••• On the basis of examinetion and/or investigation, in my opinion, deeth occurred at tha tima, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 030115 29d. Data signed (Month. Dav. Year) 8/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2600 LIBERY HETTS AVE BELTIMORE mo 21215 hiokpeha, mo 31. Data filed (Month, Day, Year)

Registrar

AUG 2 6 1999

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 45 Aupust Moses Frank /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health Baltimore coure Agnes If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** KM 20 F Months Days Hours Director 83 249-14-0904 28 03 S.C Usual Residence of Decedent 10s State 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or Nems 23a or 28a-f ahov 1 XYes 2 No Director MD Baltimore NA 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A.

14. Race - American Indian, 908 Mt. Holly Street 21229 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: 1 Never Married Married 21215-0020 Specify: Black 1 Yes 2XX Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filled within 72 honent of Health and Mental Hyglene.
Intt: If from 27 is marked other than "naturary or other traumatic avent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. 5th grade Construction Worker na Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Oliver Nathaniel Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Mt. Holly Street, Baltimore Md 21229 Allean Moses-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Arbutus memorial Park 8/28/99 Arbutus, Md 21. Signature of uneral Service Licensee 22. Name and Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in that cause on each line. 21215 Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Phlumoni Examiner Due to (or as a consequence of): Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) True Physician/Medical Que to (or as e consequence of): (aus for use a signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

Attending death. filled in by

Completed Be Certification: To

within 24 hours efter deat To the Funeral Director:

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

25. Was case referred to medical

200. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

28a. Date of Injury (Month, Day Year)

Hospital:

MID

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number D12595

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) St Agns Hogya Fa Mustapha Mallah MD Goo Caten Avenue Avenue, Baltimore, MD 21229

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

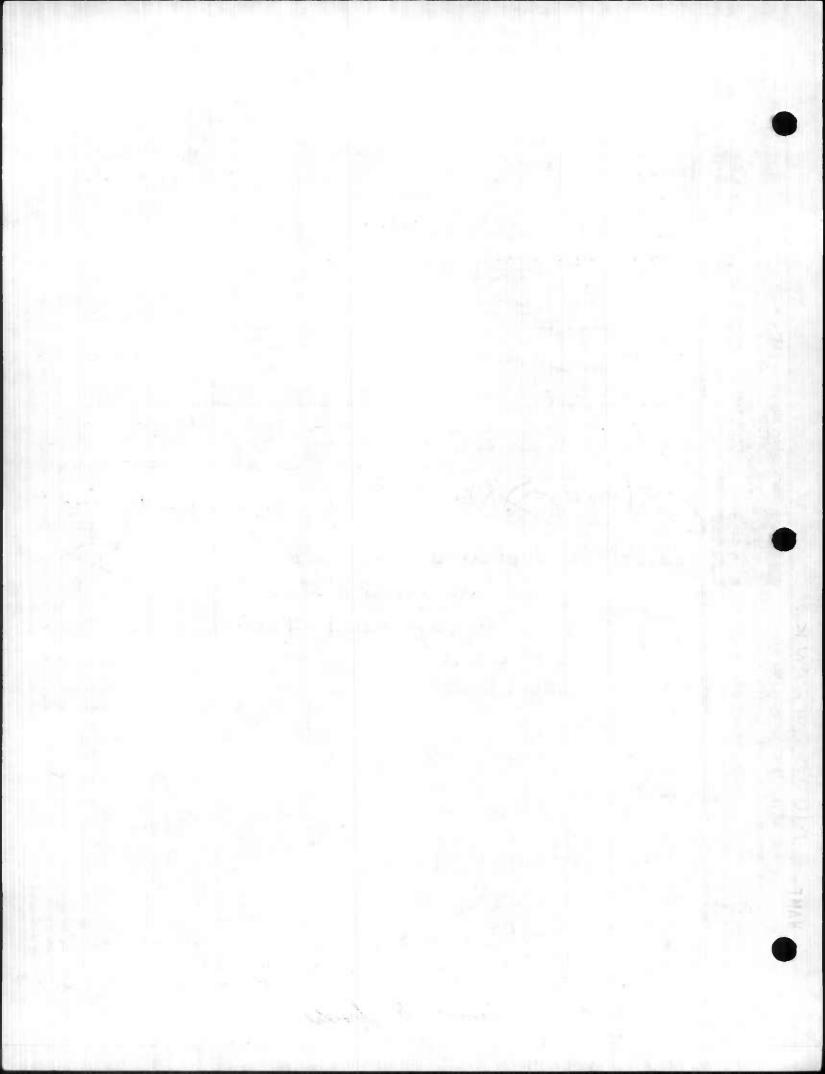
1 Yes 2 No

AUG 2 6 1999

5 Pending investigation

6 Could not be

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: ITEM: #27, 28A-F PER MEO G774 8-24-99 WR Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 100RE NULY 12:15 AM 28 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 5041 Lynn Burke Road Monrovia Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 2□ F Months Deys Hours Yrs. 79 578-16-6631 April 29, 1920 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Baldwin Park Drive #A4 21157 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Residential Elementary/Secondary (0-12) Cotlege (1-4or 5+) Apartments Manager 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Harry B. Moore Kathryn L. Roth 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Moore/daughter 5041 Lynn Burke Road, Monrovia, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donetlon 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenson Ronald So Warte 22. Name and Address of Facility Director State Anatomy Board, 655 W. Baltimore Street nama Baltimore, MD 21201 It. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ack, or heart failure. List only one cause on each line. Interval Between Onset end Deeth Immediete Cause (Final disease or condition resulting in death) STROKE RACTURED L EFT. Due to (or as e consequence of) N DATO BY Due to (or as a consequence of) 23b. Aid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1 Yes 2 No 3 Probably 4 Unknown CANCER 24e. Wes an eutopsy performed? 24b. Were sutopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PAesIdenca 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death

Physician /Medical **Examiner**

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Box 68760,

P.O.

Division of Vital Records,

Examiner

Physician/Medical

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Physician

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than "natural", or items 23a or the Medical Examiner must be.

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Department of Hear Important if them any injury

Baltimore, Maryland 21215-0020

Director

Funeral

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MD

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

LUNG

1☐ Yes 2☐ No

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Injun

28d. Describe how Injury occurred FELL DOWN STAIRS

1 Natural 2 X Accident 3 Suicide 4 - Homictde 5 ☐ Pending Investigation JUNE 30, 1999 6 Could not be

1 Yes 2 No 3:13 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State) WESTMINSTER 404 BALDWIN PL. DR.

29e. Certifier (Check only one)

HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signaty end title of cartifier

ATTENDING PHISICIAN 29c. License number

29d. Date signed (Month, Day, Year)

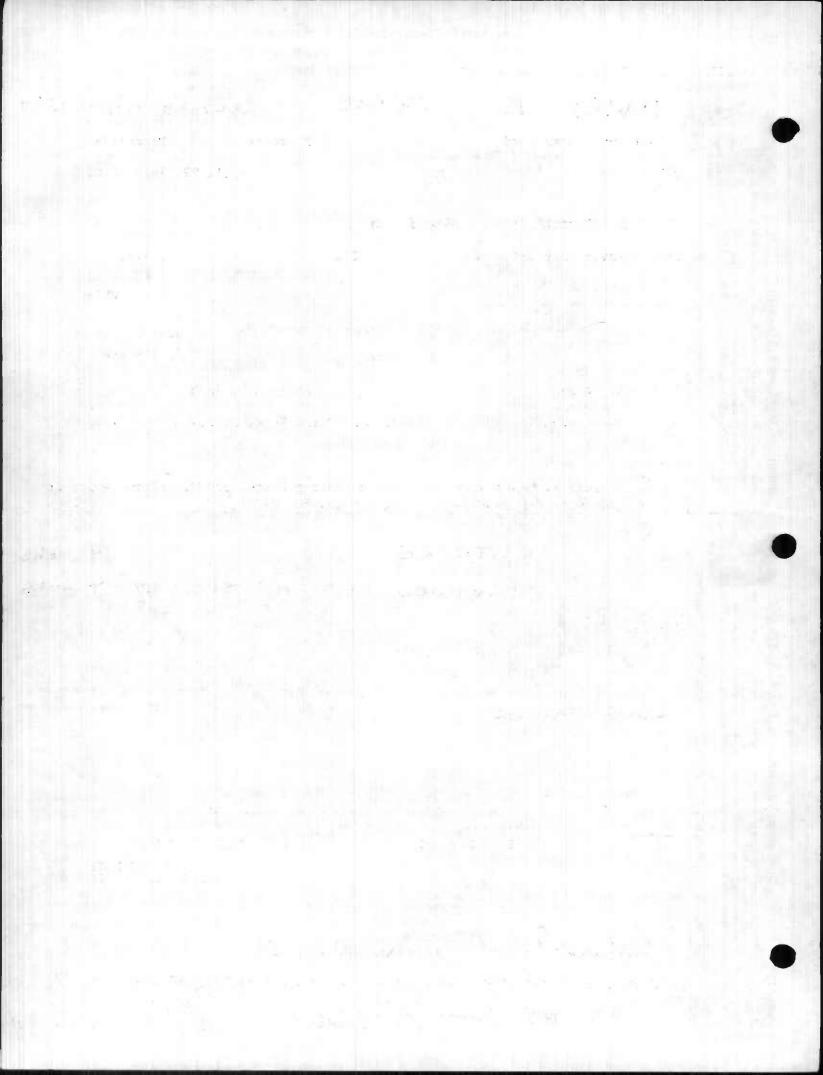
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

904 WASHINGTON RD WESTMINSTER, MARYLAND 21157 APRITUR L RUSO

31. Date filed (Month, Day, Year) 32. Registrar's Signature

AUG 2 5 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last, :30 AM **Physician** Josep Mirouski August /Medical 4a Facility Name (If not institution, give street and 579 Bright View 4b. City, Town, or Location Examiner 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** 220.58.1870 15 M 2 F Months Days Hours Director irginia Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at Millersville 1 Yes 2 No Director AACO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Drive 21108 USA Brightview Funeral 72 hours after death 12. Was Decedent Ever in U.S.

1 MYes 2 No
If Yes, Giva
Year or Dates: VIETNAN 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify Specify: WHITE à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

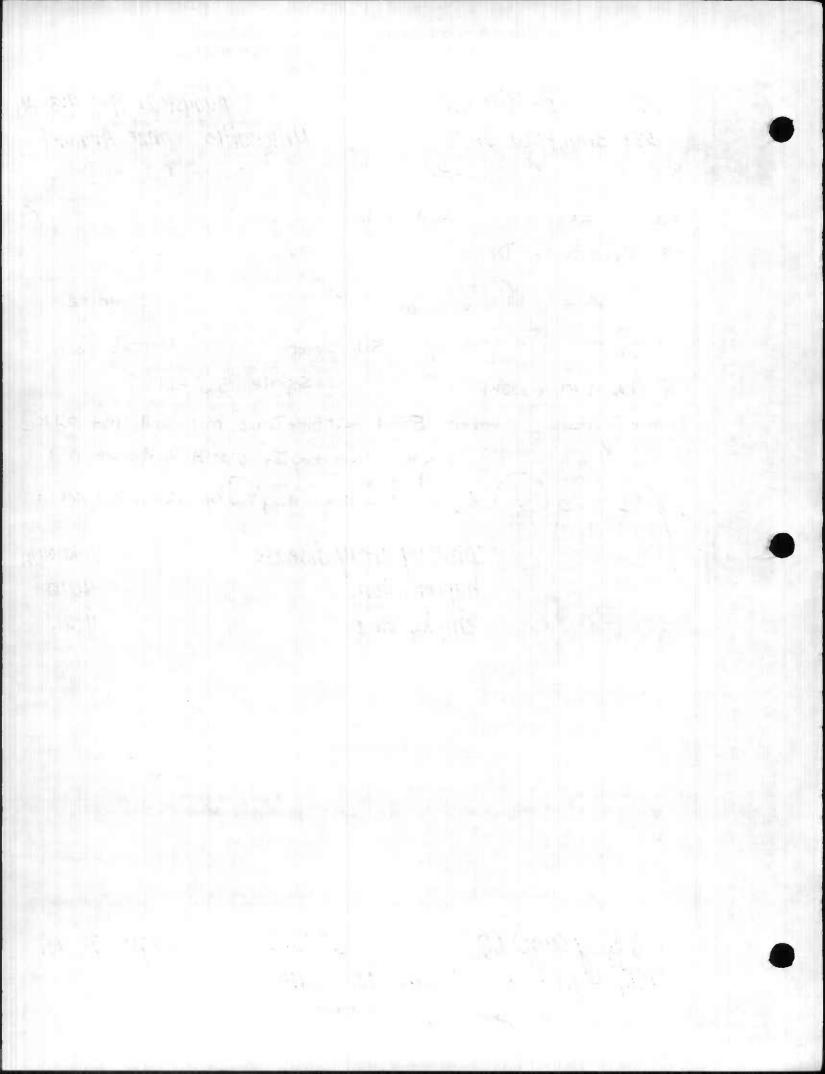
Salesperson 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry should be filled within Elementary/Secondary (0-12) College (1-4or 5+) Name Hygiene 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be nd Mental marked o Sophie Switala maddleus Mirowski le ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other tras-abse. 8331 West Side Drive Sophie Switala mother millersville mel 2/108 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Baltimore, md 8.23.99 Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fink Funeral Home Pa 21. Signature of Funeral Service Lice Hac Crain Huy Sw Glen Burnie and Approximate one cause on each line.

Approximate art1. Enter the disease hock, or heart failure. Approximate Interval Between Onset and Death Physician ediate Cause (Final ase or condition iting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last y Sema ettending physician for use es the burn P.O. Box 68760, The law requires that the deeth certificate be Physician/Medical 8 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen within 24 hours efter death.

To the Funeral Director: After this certificate has 2 19 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicel examiner?
100 Yes 2□ No Be 26. Plece of Death (Check only one) 10 Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated edical 21 Medical Examinar: On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar



State	of	Maryland /	Department	of Health	and	Mental	Hygiene	
			Cartificate	of Doot	-			

2. Date of Death

Physician	
/Medical	
Examiner	

1. Decedent's Neme (First, Middle, Last)

JOSEPH E. MAHON

and

10d. Inside City Limits

21228

1 ☐ Yes 2 No

12:10 PM

Funeral

Director 28a-f ahow ò

the Medical Examiner must be notified at should be filed within 72 hours after deal nd Mental Hygiene. marked other than "natural", or flams 2 permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Itam 27 is marked orbit any injury or other traumatic avant pages.

Baitimore, Maryland 21215-0020

Box 68760

P.O. P

Division of Vitai Records.

Physician /Medical Examiner

Examiner physician s the burial Physician/Medical been signed by the should be detached þ Completed Hospital or Attanding Physician: 8 Medical Certification: To this After To the Hospital or Atlandir within 24 hours after death. To the Funeral Director: A completely filled in by the fi death.

Month Mahon breph Ells AUG. 21, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOMESTYLE INN 6401 ROUTE#40 WEST CATONSVILLE BALTIMORE If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day 213-92-3812 1XM 20 F 35 mary Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location Baltimore Director atonsvi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Road 6120 Burn. 21228 States Dak ted 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 20 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indien, 11. Merital Status Bleck, White, etc. 1 ☐ Never Merried 2 Married 1□ Yes 2 No Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) eureler 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) 8 Joseph Kegina Marie Sr Bruns Hahon 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6120 Burnt Oak lle, mo Catonsvi Laren Mahan 20b. Plece of Disposition (Neme of cemetery, cremetory or other p Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 ☐Removel from State Memorial 8 Maryland 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Ambrose Funerat 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel Shotgun disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. Wes en eutopsy sertial

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

2 No

24b. Were eutopsy findings available prior to completion of cause of death? yes 2□ No

25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6XOOther (Specify) AT SCENE XX Yes 2□ No 1 Inpetient 2 ER/Outpatient 3 DOA 27. Menner of Death 1 Netural

28b. Time of 28a. Dete of Injury (Month Day Year) 5 Pending investigation 8-21-99 11:50

28c. Injury at Work? 1 ☐ Yes 2/ZINo 28d. Describe how injury occurred self inflicted shoten

6 Could not be determined 28e. Plece of Injury - At home, ferm, building, etc. (Specify) int, fectory, office 4 Homicide (Comobile Inn Building | Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and menner as stated.
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

hukw

28f. Location (Street and Number or Rorel Route Number, City or Town, Stete) 6401 Rt 40 West

29b. Signeture and title of certifier

2 Accident

3 Suicide

29c. License number O.C.M.E 29d. Dele signed (Month, Dey, Year) AUG. 22, 1999

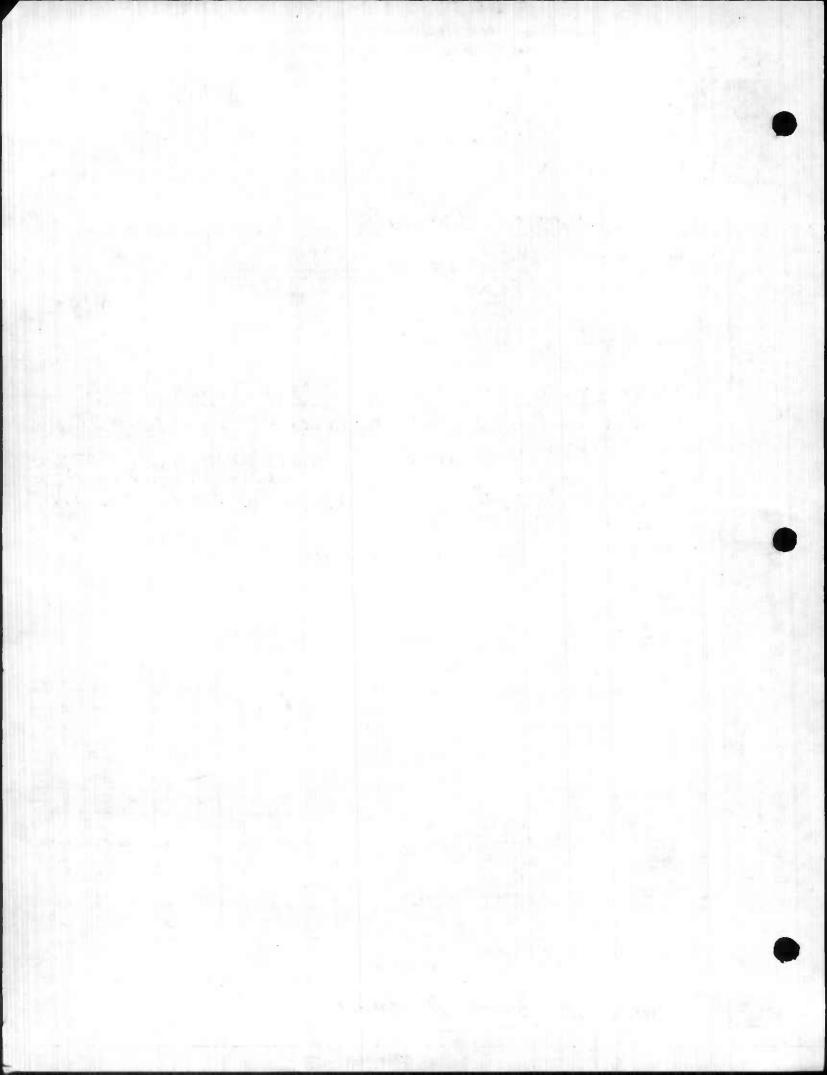
30. Name and address of person we cor completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 lennis

State Registrar

31. Dete filed (Month, Day, Year) AUG 2 6 1999

32. Registrar's Signety of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #26 PER MD G774 8-26-99 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death - the 1999 AUGUST 13 5:30 p.m 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death n/a THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs Months Deys Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Deys 1 M 2 1 Months 52 230-58-1779 1946 Va. Oct. 27, Usual Residenca of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Woodlawn 1 Yes ZXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6813 Townbrook Drive Apt. C USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ₩ Specify: Specify: Black 3 ₩Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nations Bank 12th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert Pearson Ethel Easter 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jamica Nole-Cosby 6813 Townbrook Drive Apt. C Baltimore, Md. 21207 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 urial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Aug. 19 Brunswick Co., Va Pearsontown Family Lot 22. Neme end Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Service Licenses ε. nutter 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fine) disease or condition resulting in death) hernia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequença of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2000 1 Yes 2 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

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Hospital

Box 68760

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

Funeral

Director

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Md.

Directo

Funeral

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Completed

Be

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medical ģ Completed Be

25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide

5 Pending investigation

6 Could not be determined 4 Homicide

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Dete of injury (Month, Day Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. (Check only 29b. Signature and title of certifie

29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year) AUG 13, 1999

30. Name and address of bee who completed cause of death (Item 23a) (Type, Print)

Richman 32. Registrar's Signature

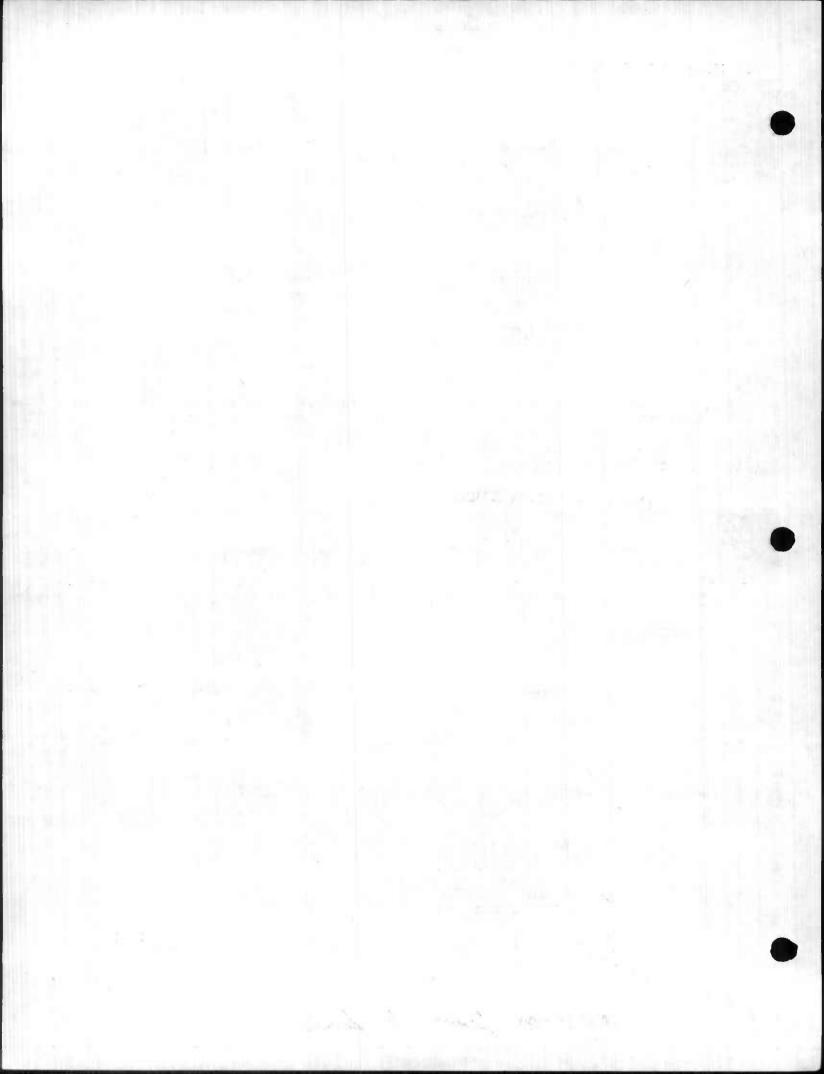
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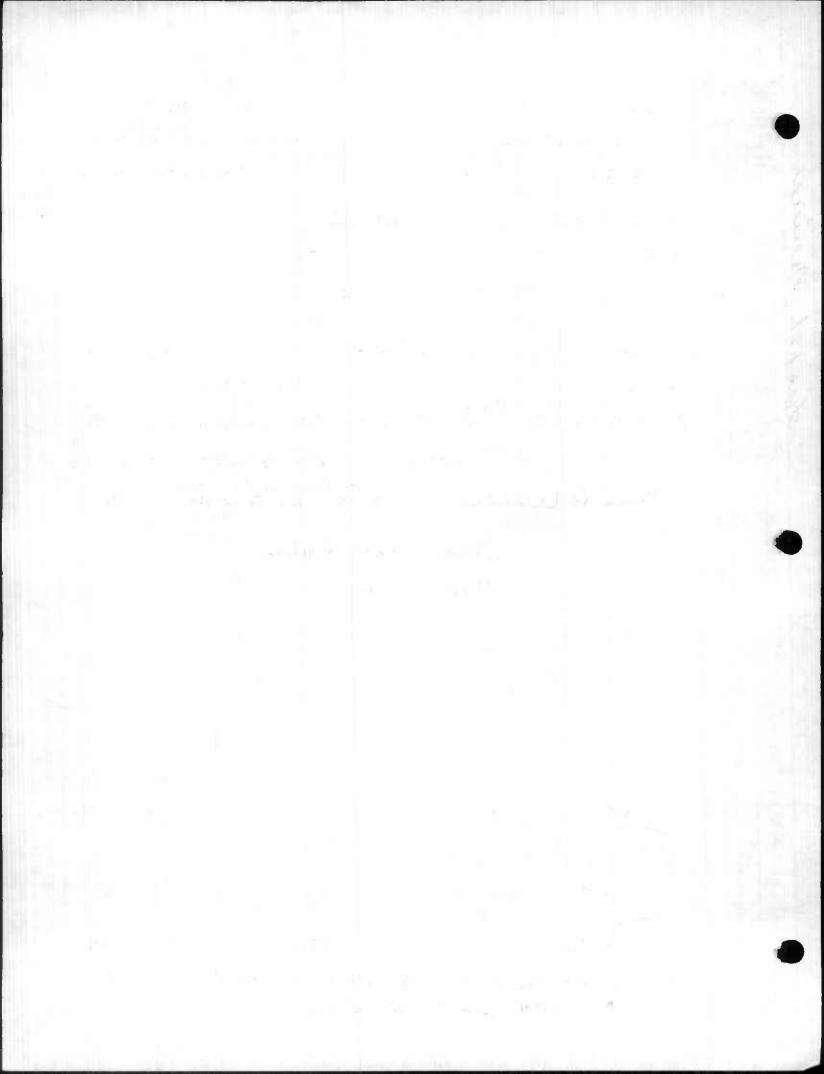
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Leah August 24, 5:10 PM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium ff Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
Feb. 16, 1918 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 20XF 81 Maryland Yrs. Director 214-22-0632 Usuat Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. "natural", or items 23a 11 Deer Pass Court 21030 Funeral 12. Was Decadent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Completed traumatic event, the Maulcal 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other than College (1-4or 5+) Pages 1 and 2 should be filed with nant of Haalth and Mental Hygiena. Assembler Manufacturing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Lutz Ruby Osburn 19a. Informant's Neme/Relationship (Type, Print) (Grand-19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traur Patrick P. Platt, III son) 11 Deer Pass Court, Cockeysville, MD 20a. Method of Disposition

N Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 8/27/99 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Servica Licansee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Deeth **Physician** Failure Chronic Renal /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner ypertension bunial-trans Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of) The law requires that the death certificate be axec Box 68760. Physician/Medical the Due to (or as e consequence of): USe as P.O. Part II. Other algorificant conditions contributing to death but not resulting to the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yas 2 No Records, þ peq paga 2 should 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Definer (Specify) 1405 mice Hospitel: 1 ☐ tnpatlent 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No SILIS the funaral 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Division or Attending 1 Neturel 5 Pending Investigation 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and ptece, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pteca, and due to the cause(s) and manner stated. Medical To the Hosp within 24 hou To the Fune complately fi (Check only one) 29b. Signature and Nie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 143725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIG MAHMOOD 201-109 Back River Necle Read 32. Registrer's Signature State Registrar

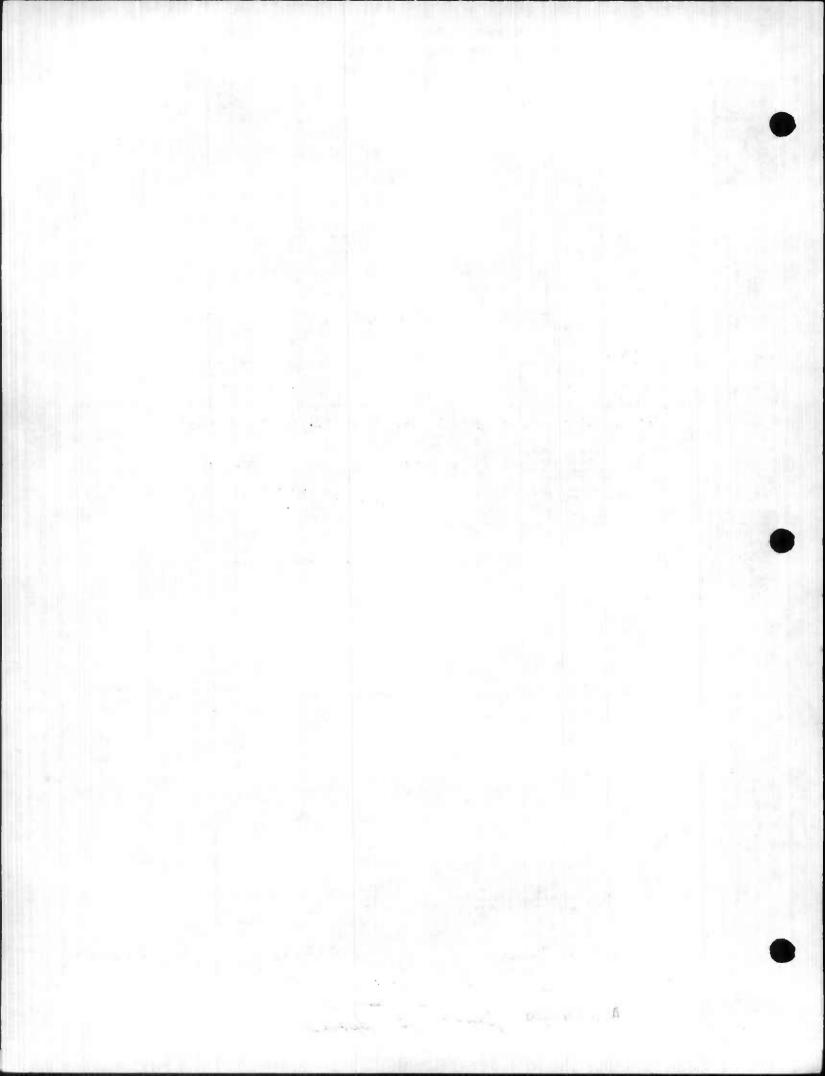


State of Maryland / Department of Health and Mental Hygiene

				Certific	cate of	Death		R	eg. No.	5 6	6/18			
	1. Decedent's Nama (First, Middle, La						2. Data of Dea Month	_	Vans	3. Tima of Death				
Physician /Medical	James Albert Naw					1	August	23 19	999	11:40 P.M				
Examiner	4a Facility Nama (If not institution, give		4b. City, To	of Death	Seath									
	Mariner Health o						est I			Harford				
Funeral Director	5. Social Security Number 6. S 216-01-7675 Usual Rasidence of Decedant	Sex 7. Age 7. Age 85	(In yrs. last b		Under 1 Yaar nths Days	If Under Hours	24 Hrs. Min.	8. Data of Birth (Month, Day April	ta of Birth onth, Day, Year) ril 9, 1914 9. Birthplaca (State or F Country) Maryland					
P 8 11	10a. Stata 10b. County		10c. City, Tov	vn or Location	n					1	10d. Inside City Limits			
with the Maryland t or 28e-f show be notified at Director	Maryland Harford Fallston 100. Street and Number 100. Zip Code								1 ☐ Yes 2					
ath with 23s or suit be ral Dir	2405 Derby Drive			21047				U.S.A.						
2.12.15-0020 divibile 72 hours after death with the Marylai gleen. The Madical Examinar must be notified at the Madical Examinar must be notified at Completed by Funeral Director	11. Marital Status 1 □ Nevar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yas 2 N If Yas, Giva A Yaar or Datas:		If Yas	Decedent of I , specify Cub as 2 No	lispanic Or an, Maxica Specify:	n, Puarto	ecify Yas or No- Rican, atc.)		e - Amaric ck, Whita,				
ind 21215-00, to fired within 72 hours hours the Hygiena, d other than "natural" went, the Medical Expension of the Medic	15. Decedent's Ed (Specify only highest gra		168	(Giva kind	Usual Occup of work dona	during mos	at of worki	ng	16b. Kind of Bu	usinass/Ind	dustry			
mple Men	Elementary/Secondary (0-12)	College (1-4or 5-		lifa. DO N	OT use retire	d)								
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	17. Father's Name (First, Middle, Last, Stanislaus Nawro							(First, Middle, I	waidan Suman	1a.)				
should by merked merked umerked	19a. Informant's Name/Ralationship (10	h Mailine Ad	Ideana /Otenat		-	/linski Routa Number, City or Town, Stata, Zip Coda)						
md 2 sh aith and 27 is m r traum	Constance Silves	• • • • • • • • • • • • • • • • • • • •						llston,		31418, 210 047				
re, n Health Ism 27 other tr	20a. Mathod of Disposition	cri (baagn	20b. Place 0	of Disposition	(Nama of		1 4.	- T	20c. Location -		own, Stata			
Dallmore, semil. Pages 1 a Separtment of Hea mportant: If them my injury or othe RGB.	1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility							/27/99	Dunda1	k, Ma	aryland			
Demit. Departs Imports any inju	21. Signature of Funaral Service Licer	ral 1	1 Home of Bel Air, Inc. Road, Bel Air, MD 21014											
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rificate be executed ng physician and see the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of):													
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The law sie has bege 2 s								1 🗆 Ya	s 20 No	10	Yas 20 No			
certificate rector, pag	25. Was casa rafarred to medical					26. Place	a of Death	(Check only or	a)					
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Attending Physical Control of the funeral diffication: To	27. Manner of Death 1 Natural 5 Pending invastigation	26a. Data of Injury (Month, Day	Year) 28b.	Tima of Injury	28c. Inju				. Dascribe how injury occurred					
DIVISION OF tal or Attending Phys is after death. In Director: After this, led in by the funeral di Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmined	One place of trium. At home form cheet factors office						281. Location (Si City or Town		er or Rure	I Routa Number,			
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page. Medical Certification: To Be Com	29a. Cartifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of a and mannar state	axamination ar	e, death occu nd/or invastig	urred at tha til ation, in my o	ma, data ar opinion, das	nd place, a	and dua to tha c ed at tha tima, d	ausa(s) and ma ata and place,	annar as s and dua to	tated. o tha cause(s)			
Vithin To the Somp	29b. Signatura and titla of certifier		-11		29c. Licens	a number		- 2	9d. Data signe	d (Month,	Day, Year)			
00	Daved 5.	Du			0:	3225	7	1	2 0	, ,	1995			
1/10	30. Nama and address of person who	completed cause of de				1	.1		The	-1,				
'Mail	Dov. 25.3.	م برد		es5 M	100 Ph	n:/								
State Registrar	31. Data filed (Month, Day, Year) AUG 26 1	32. Registra	rs Signatura	A	7		•							

DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 22 Charity Queen :45 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Mary land Medicine System Baltimore City If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) N.C. 5. Social Security Number 6. Sex 1□ M 2₩ F 213 36 6042 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1#1 Yes 2□ No N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 PENNSYLVANIA AVE. (APT 6) 21217 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Stalus 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2# No If Yes, Give 1 Never Married 2 Merried Specify AFRO AMERICAN 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HO:1E 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WILLIAM S. MOORE SR. TRENE G. MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) SHANNON QUEEN 4108 BELVIEU AVE. BALTO. MD. 21215 (3rd floor) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐#Burial 2 ☐ Cremation 3 ☐ Removel Irom Stete RANDALLSTOWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) KING,S PARK 8/28/99 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility ESTEP BROTHERS FUNERALHOME P .A. 1300 EUTAW PL BALTO. MD. 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of) Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or es e consequença ol) Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Congestive 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Neturet Accident 5 Pending investigation 1 Yes 2 No

physician and the burial-transit The law requires that the death certificate be axecuted Box 68760. 980 P.O. Records. of Vital this funeral After Division

Physician/Medical Examiner þ Completed Be To edical Certification:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Nams 23 any Injury or other traumatic event, the Marian

Physician /Medical

Examine

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

the Maryland

or Attending Physician: Fo the Hospital or Attenditivithin 24 Nourselfer death. To the Funeral Director; A. filled in by

within 24 hor To the Fune completely fi State Registrar

DHMH 16 Rev 6/95

AUG 26 1999

6 ☐ Could not be

29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephent. Woods MD 22 S. Greene Bultumore MB 21201

28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year)

3 ☐ Suicide

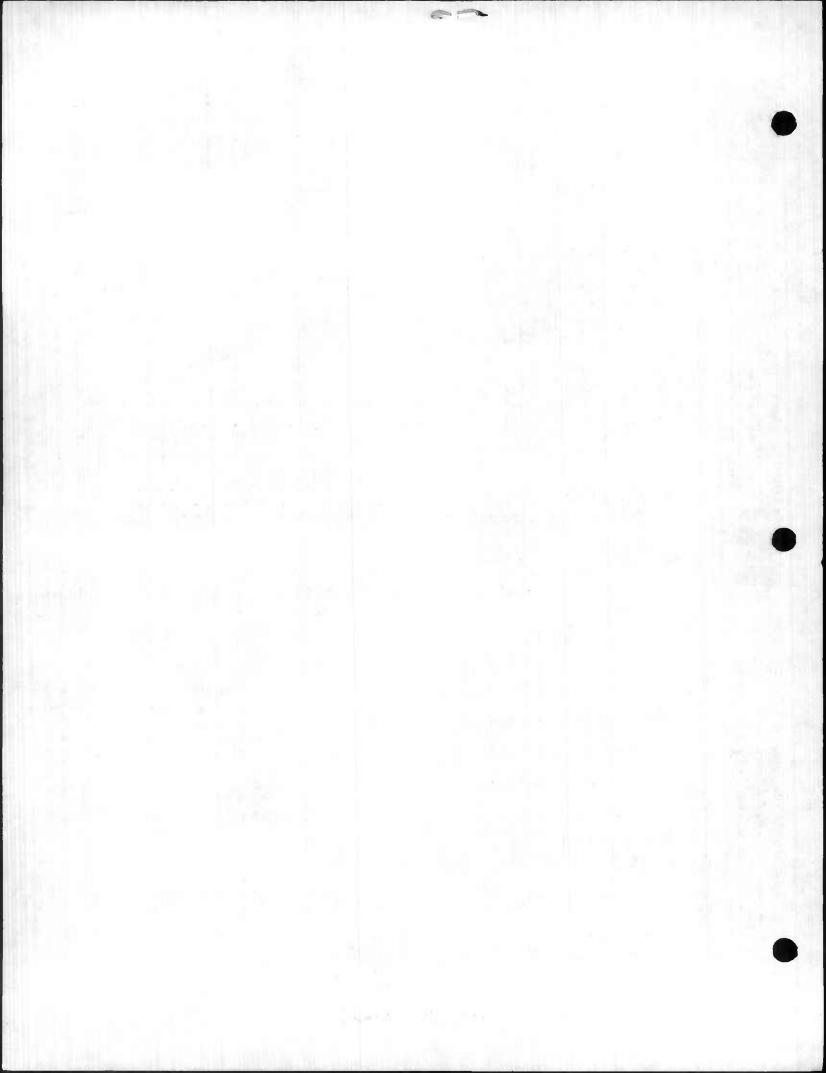
29e. Certifier

4 T Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature



State Registrar DHMH 16 Ray 6/95

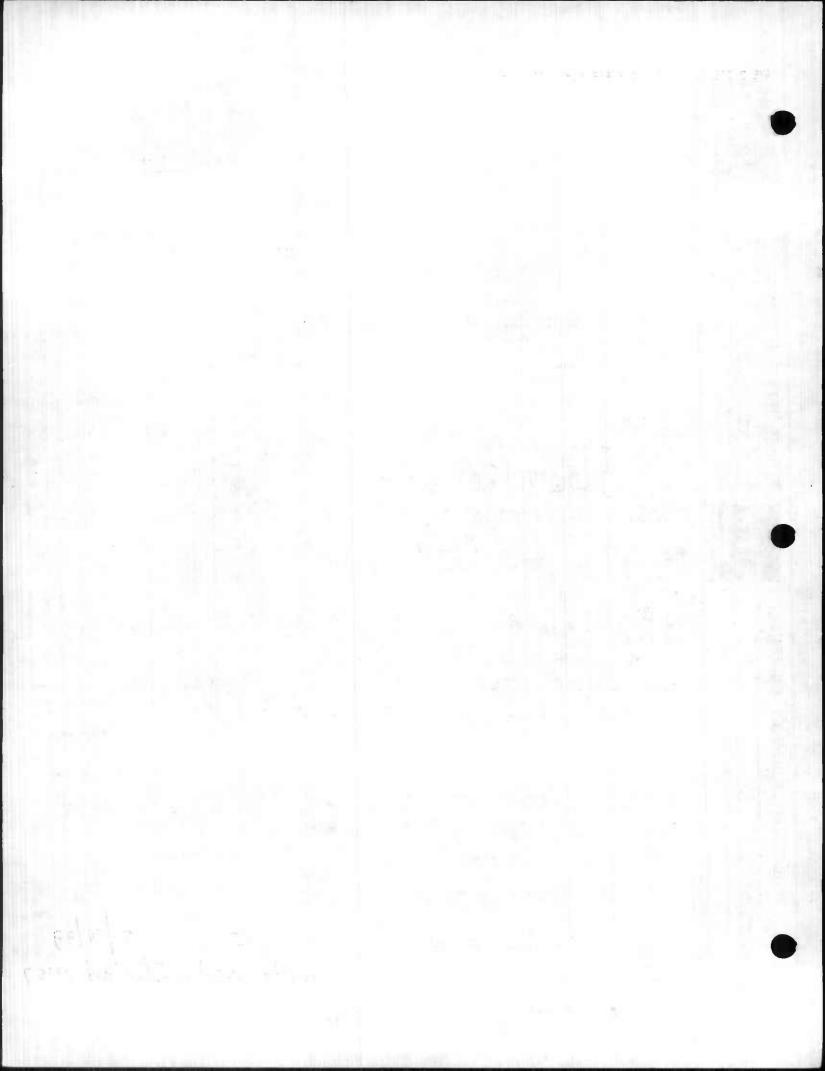
AMEND ITEMS: #8, 7, 10F PER F.H. G775 9_3_99 WR.

1. Decedent's Name (First, Middle, Last) **Physician** Ranchhod1a1 Patel 1999 AUG 24. 10:49am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4305 Jefferson Avenue Sykesviii Under 24 Hrs. North Min. Bay, Year) 1933 DEC 14, 1932 Carroll 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days XOM 20F 385-40-0350 Director 65 India **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Carrol1 Sykesville 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4305 Jefferson Avenue 21228 21784 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours effer Hygiene. Wher then "neturel", or its 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: speciasian Indian à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Deportment of Health and Mentel Hyglan, Important: if item 27 is marked other tha eny hojury or other traumatic event, that page. Chemist Textile Dye 17. Father's Name (First, Middle, Last) 16. Mother's Neme (First, Middle, Maiden Sumeme) Be Ambalal Patel Dahigauri Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Samir R. Patel/son 297 Donerail Ave. Powell, Ohio 43065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 N Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 08/25/99 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral & McDonald Cremation Society of Maryland, Inc. Dawn V 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Examine physician and s the buriei-fransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown iabel à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No of Vital 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? To the Hospital or Attanding Pi mint 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28d. Describe how injury occurred Division Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 26f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of certifier 23015 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.KALARIA

> 31. Date filed (Month, Day, Year) AUG 26 1999

32. Registrar's Signature

217 Washie



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

26781

Funeral

Director

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1. Decedent's Neme (First, Middle, Las.	11							2. Dete of De	oth.			2 Time	of Death
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Donato L. Pozon,								August		199		12:	20 P.M
4a Facility Name (If not Institution, give	street and number)					4b. City, To	own, or L	ocation of Deet	4c. C	ounty o	of Death		
Rocks State Park,	King & Qu	een's	Seat			Jarr	etts	ville	Н	arf	ord		
5. Social Security Number 6. Se		e (In yrs. la	ast birthday,	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	th Year		9. Birthp	lace (Stel	e or Foreign
364-88-7754	M 2□ F	3:	2 Yrs.	MOTILIS	Days	Hours	IVIIII.	Oct.	30. 1	966	Phi 1	ippi	nes
Usual Residenca of Decedent									, ,	,,,,			
10a. Stete 10b. County		10c. City	, Town or L	ocation							1	0d. Inside	City Limits
Marral Palatana		D-	11	-11								1 🗆 Y	es 2 No
Maryland Baltimor	е	Pe	erry H	10f. Zig	Code				10g. Citize	n ad 144	hat Cour	ntn./2	
Toe. Street and Number				101, 21	C008				Tog. Citize	SII OI VV	riat Cour	ntry r	
4410 Cole Farm Ro			212	236				Unit	ed S	State	es		
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1 Never Married 2 Merried	Armed Forces? 1 ☑ Yes 2 ☐ f If Yes, Give	No						Thouse, ote.,					
3 ☐ Widowed 4 ☐ Divorced	Year or Detes:			1 ☐ Yes	200 NO	Specify			S	pecity:	Asia	an	
15. Decedent's Edu	cation		16a. Dece	dent's Usu	al Occu	pation		-	16b. Kind	d of Bus	siness/inc	dustry	
(Specify only highest grad	le completed)		(Give	kind of wo	rk done	during mos	st of work	king					
Etementary/Secondary (0-12)	College (1-4or 5	i+)								gove	ernme	ent	
	4		STECE	rical	en	ginee:		a (Final Adiabat)					
17. Father's Name (First, Middle, Last)						is. Moth	ers Nam	e (First, Middle	, maiden S	urn eme	"		
Donato L. Pozon.	Sr.					Lo	renc	ita					
19a, Informent's Name/Relationship (T			19b. Mait	ing Address	s (Street	and Numb	er or Ru	ral Route Numb	er, City or	Town, S	Stete, Zip	Code)	
Alona Pamukcu - si	ster		1325	0kla	homa	9	Wate	erford,	Mich	igar	1 48	8327	
20a. Method of Disposition	0001	20b. Pl	ece of Disp	osition (Ne	me of			Date			City or Town, State		
1 ☐ Burial 2 🖾 Cremation 3 ☐ I		metery, cre			(CO)								
4 □ Donation 5 □ Other (Specify,		Aub	urn C					3/27/99	Roya	al (ak,	Mich	igan
21. Signature of Funeral Service Licent	160		2	2. Name er	nd Addre	ess of Facit	ity Lo	udon Pa	rk fu	ner	al H	ome	
Manua.	ZUNK						_					21229	
Baltimore, Maryland 3a. Penti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,										III.	Approxir	nate	
shock, or heart tellure. List brily o	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. Let priv one cause on each line. Approximate Interval Betw. Onset and D												
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disease or condition resulting in deeth)	Multip	Te II	ijurie	25							i		
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Sequentially list conditions,		Due to (or	as e conse	quence of):							1		4-1
if any, leading to immediate cause. Enter Underlying													
Cause (Diseese or injury that initiated events	C	Due to (or	es e conse	nence of									
resulting in death) Lest		(4)									1		
	d							_					
Pert II. Other significant conditions co	ntributing to death be	ut not resu	tting In the u	inderlying o	cause gi	ven in Pert	1.	23b. Did	tobacco u	ae con	tributs to	the cau	ss of death?
								1 🗆	Yes 2	No	3 Pro	bably 4	Unknown
									an autops	У	24b. W	ere eutop	sy findings or to
				-				point	3111001		co	mpletion deeth?	
								V	Ne		300	DN-	
								174	Yes 2	NO	15	Yes 2	2□ No
25. Was case retarred to medical examiner?	Unanital:							th (Check only					
ILVIES STING	Hospital: 1 Inpatie	nt 2 E	ER/Outpatie		UA		ursing H	ome 5 Resi					
27. Manner of Death	28a. Date of Injui	Year)	28b. Tima o Injury	of 2	28c. Inju Wo	ry at		28d. Describe	how injury	occurre	Sub	ject	fell
1 □ Netural 5 □ Pending investigation	08-21-19		11:50	M		Yes 2	No	while rock climbing					
3 Suicide 6 Could not be	28e. Plece of Inju	iry - At hor	me, ferm, st		y, offica			28f. Location (28f. Location (Street and Number or Rurel Route Numb City or Town, Stele) ROCKS State Pa				lumber,
4 Homicide	building, etc		State					City or To	wn, Stete)	Rocl	ks S	tate	Park
Mo Codffee and a state of	-1-1 T- 0						- 4 - 6	Jarret	tsvil	le,	Mar	yland	1
(Check only 2 Medical Exam)	sician: To the best of ner: On the basis of	examinati											e(s)
one) A	and manner ste	ited.						actement of the					
29b. Signeture and title of certifier				29	c. Licen	se number			29d. Date	signed	(Month,	Dey, Yea	r)
Ma Olaha II	he Unil	L D	W		0	.C.M.I	Ξ.		Augu	st 2	22.	1999	

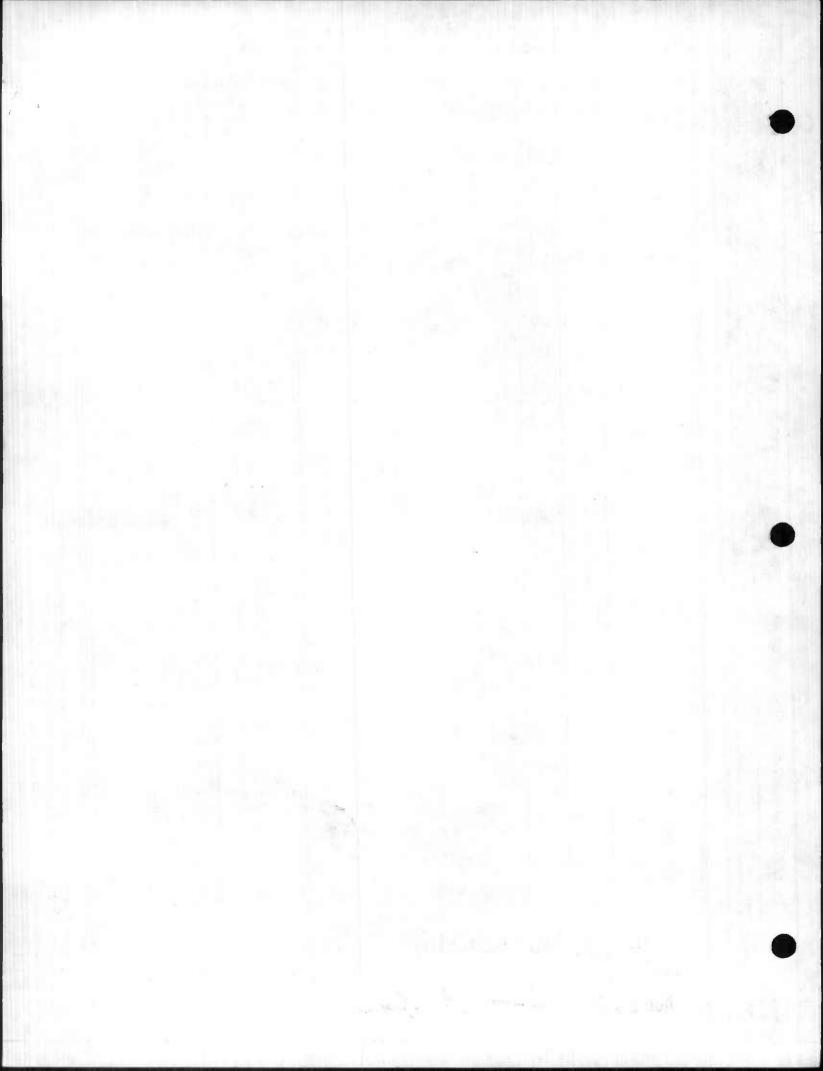
State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 234) (Type, Print)

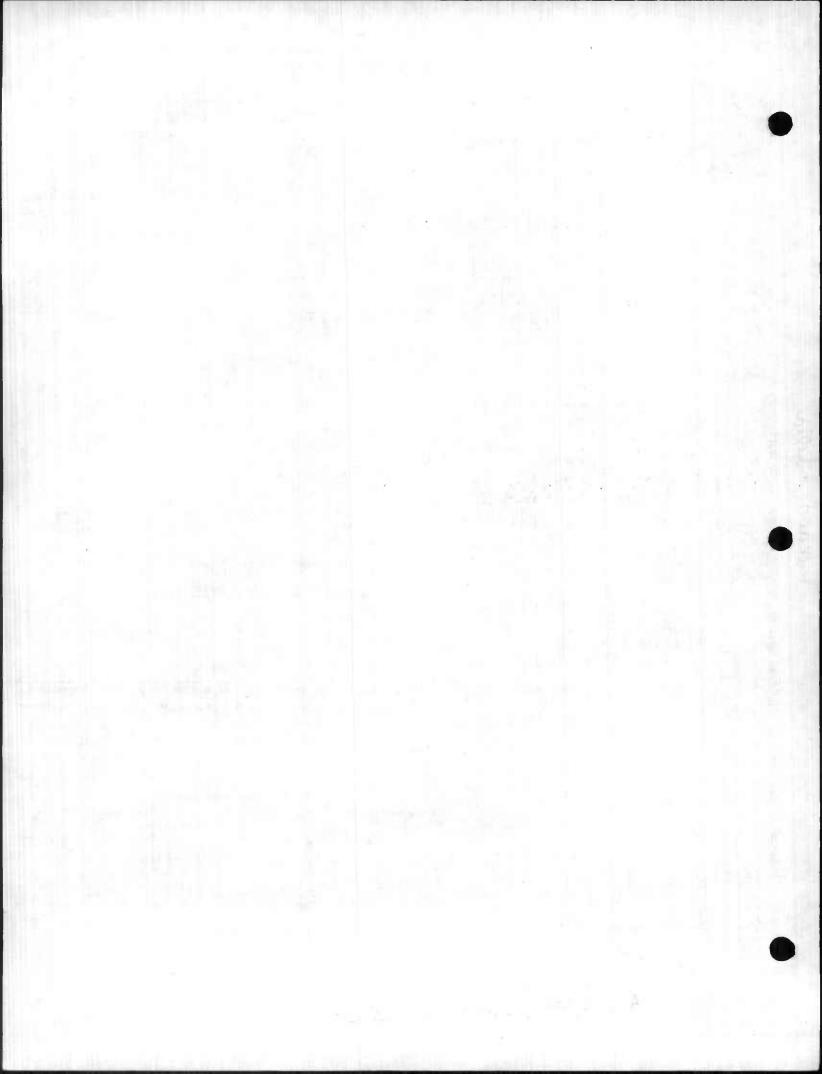
Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 99

e 99 26782

		42	Certificate of Death Reg. No.									
Physician /Medical	1. Decedent's Neme (First, Middle, La	Packard			0.00	2. Date of Do Month AUGUST	Day 19	3. Time of Death 2:17 PM				
Examiner	4e Fecility Neme (If not institution, giv GREATER BALTIMO)	N.	- F			or Location of Deat	th 4c. County of BALTIN					
Funeral Director	213-14-5848	7. Age (In yrs.	To Yrs.	If Under 1 Year Months Days			rth ey, Year) 14, 1922	9. Birthplace (State or Fore Country) Mass.				
be notified at Director	Usual Residence of Decedent 10a. Stete 10b. County	The state of the s	y, Town or Lo			15	10g. Citizen of Wh	10d. Inside City Lim 1 Yes 25				
ather or all Dir	39 Cedar Hill Rd.	3.0		21133		,	USA	at County:				
st, or thems 23a or 28a-f a Examiner must be notified by Funeral Director	11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 U Yes 2 No If Yes, Give Yeer or Detes:				(Specify Yes or Nerto Rican, etc.)		14. Race - American Indian, Black, White, etc.				
ther than 'naturent, the Medical. Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	ducation ide completed) College (1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire e maker	during most of w	vorking		of Business/Industry				
Be ag	17. Fether's Name (First, Middle, Last, Peter J. Finneg.		110111	e maker			Own home e (First, Middle, Maiden Sumame) Tierney					
auma auma	19e. Informent's Neme/Reletionship (Mary Packard/daug		1			Rural Route Numb	ber, City or Town, S Md. 2112					
ury or other tr	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removed from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, cremetory or other place) Arlington National Cem. 8/31/99 Arlington.											
any inju	21. Signature of Funerel Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204											
rding physician and use as the burial-transit	Due to (or as a consequence of): Intraaddom al Catastrophe Due to (or es a consequence of): Due to (or es a consequence of): Cause. Enter Underlying Cause. (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of):											
	Part II Other steelfleent and litera	d.	22b Did	23b. Did tobacco use contribute to the cause of dea								
igned by the atte be detached for by Physicia	Adms corum			oladde		1 Yes 2 No 3 Probably 4 Unkn						
has been sige 2 should mpleted	with liver	Faten	asi			peri	s an autopsy formed?	24b. Were eutopsy finding available prior to completion of cause of death? 1 Yes 2 No				
rector, page Be Com	1 Yes 2 No 1 25. Was case referred to medical 26. Place of Death (Check only one)											
T die	examiner? 1 Yes 2 Mo 27. Menner of Death 1 Molturel 5 Pending 2 Accident investigetion		(Specify)									
ral Director: After the line of the line o	3 Suicide 6 Could not b determined	City or To	 Location (Street and Number or Rural Route Number, City or Town, Stete) 									
Funeral Distriction of the Puneral Control of		yalcian: To the best of my kno niner: On the basis of examine and menner stated.										
aw We	29b. Signeture end title of certifier	Faraday	MO		se number) 439	37	29d. Date signed 8/24	(Month, Day, Year)				
8	30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	N/Cla	unles St	- Ralt.	no Mo				
State	31. Dete filed Ald G. 2 6 ea go	32. Registrar's Signa	ature 4	1	, 0 000		1	mal Mo 21204				

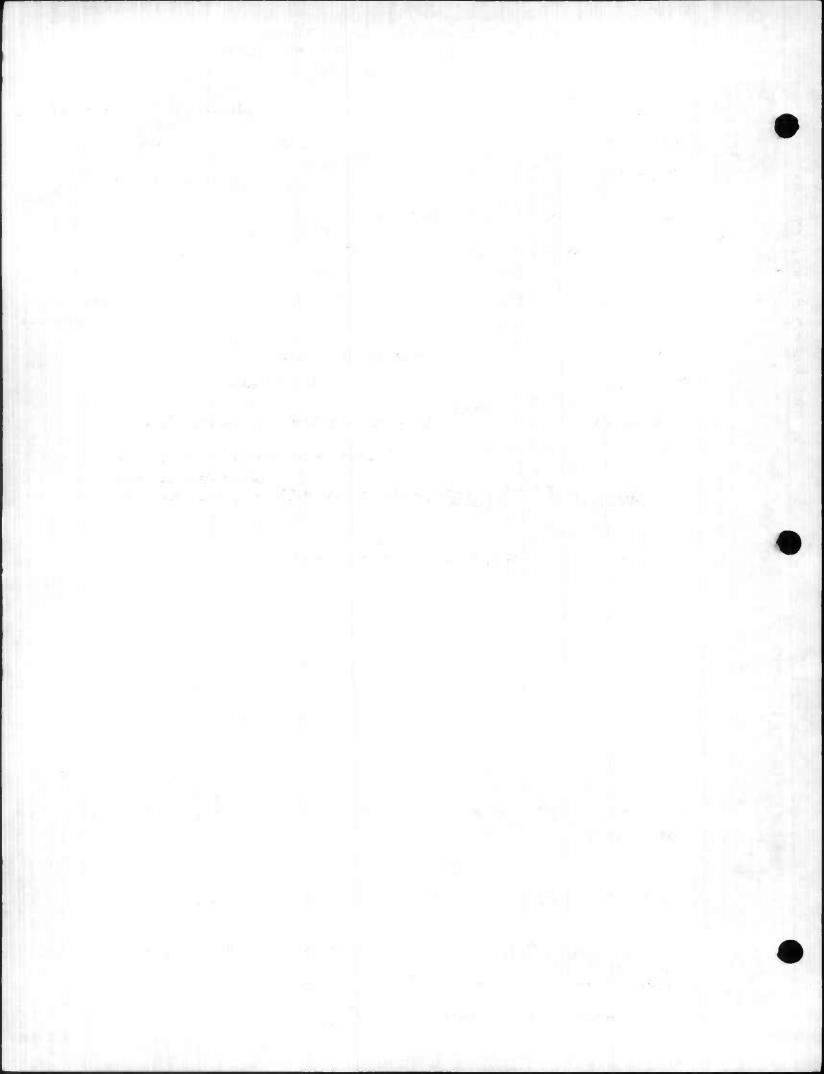


1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Rice 4:06pm Cobert Ansno 1 1999 21 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1€M 2□ F Months 73 Yrs Director 248-34-6562 March 5, 1926 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location r 28a-f show 10d. Inside City Limits Md. n/a Baltimore Director 1 Xes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "neturel", or items 23e or 4017 Liberty Heights Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1. Yes 2 No If Yes, Give Yeer or Dates: Specify: Black þ 3 Widowed Divorcad Completed traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Un Known other than Elementary/Secondary (0-12) 1 end 2 should be filed withi Heelth end Mental Hygiene. em 27 is merked other than College (1-4or 5+) 11th Grade Laborer-Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Rice Annie Foster 19a. Informant's Neme/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth er important: if item 27 is eny injury or other trau Laura Cornish 5 Vernon Hill Court Baltimore, Md. 21228 Baltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 XXBurial 2 Cremation 3 Removal from State Garrison Forrest VeteransAug. 26 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses derber 2501 Gwynns Falls PKWY Baltimore, Md. 21216 witter 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final Aspiration Prinmonia disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting In death) Last pue Due to (or as e consequence of) Box 68760. The law requires that the death certificete be Physician/Medical Due to (or as a consequence of): Part II. Other aignificent conditione contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Compieted 24a. Was en autopsy performed? 1 Yes Division of Vital or Attending Physician: effer death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Naturel investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) AS 2402321-RHZAS6 August 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Singi 20y Hanni 31. Date filed (Month, Day, Year) 132. Registrar's Signature Hannki State Registrar AUG 25 1999 **DHMH 16 Rev 6/95**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Gertificate of Death



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth Month ROSE August GEORGE, J 23 5:11 AM 1999 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Veterans Hospital in Baltimore Marsland 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 5. Sociei Security Number 6 Sax Birthplace (State or Foreign Country) 10M 20 F Months Deys Hours Yrs. 223-32-7145 V.A Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3409 Washington Ave 21244 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 N Yes 2 No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry

Packer

22. Name and Address of Fecility March F/H West

28ti. Injury at Work?

29c. License number

1 Yes 2 No

20b. Plece of Disposition (Neme of cemetery, crematory or other place)

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

1 Empatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

CANCER

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, he Medical Examiner must be notified. altimore, Maryland 21215-0020 Physician /Medical Examiner s the burialcertificate be 12 8 200 od by t

Physician

/Medical

Examiner

10e. Stete

MD

Elementery/Secondary (0-12)

17. Fether's Neme (First, Middle, Last)

Tolbert Rose

19e. Informent's Neme/Reletionship (Type, Print) James Rose-Son

4 Donetion 5 Other (Specify)

21. Signeture of Funerel Service Licenses

1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State

10th grade

20e. Method of Disposition

Immediate Ceuse (Final diseese or condition resulting in deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

290. Signature and title of certifie

31. Dete filed (Month, Dey, Yeer)

5 ☐ Pending

investigation

6 Could not be

BOBUR

1 Yes 2 No

27. Manner of Death 1 Matural

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29a, Certifier

Director

Funeral

P

Completed

Funeral

Director

Examine Physician/Medical þ Completed certificate has t lirector, page 2 s Be 2 Bills Certification: f or Attending P after death. Director: After 24 hours Medical To the 1 within 2 To the 9

Division of Vital Records, P.O. Box 68760

State Registrar

AUG 2 8 1999

32. Registrer's Signature

College (1-4or 5+)

PHEUMONIA

ESOPHAYERL

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

20 he and address of person who completed cause of death (flem 23a) (Type, Print)

> STREET, HORON ON

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Goetzes Meat Packing

20c. Location - City or Town, State

21244

21215 Approximate Interval Between Onset and Deeth

18. Mother's Name (First, Middle, Maiden Sumeme)

Date

Callie Jones

3409 Washington Ave, Baltimore Md

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Crownsville VA Cem. 8/27/99 Crownsville, Md

24b. Were autopsy findings available prior to

24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Flural Floute Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month; Day, Year)

23,1999

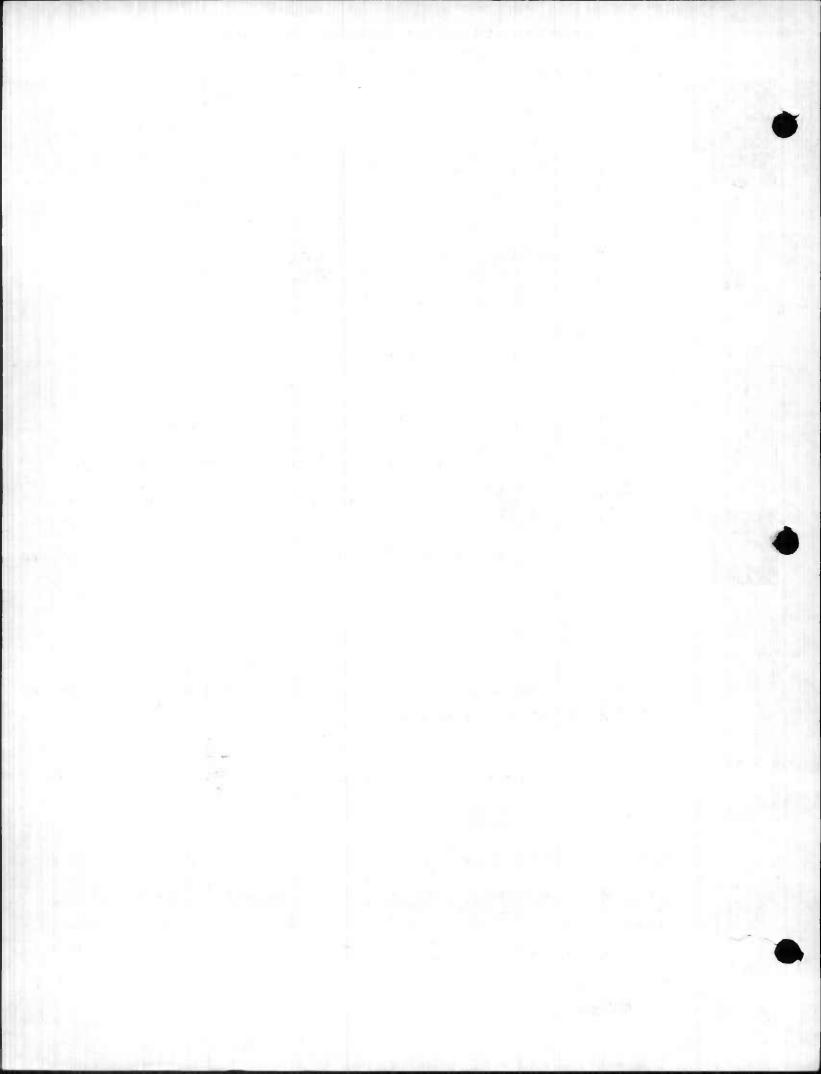
BARNORE, MD 21201

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State of Maryland / Department of Health and Mental Hygiene

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						C	Certifi	icate	of	Death	1	Re	g. No.			100	
П	Discorte	,	1. Decedent's Name (First, Middle,	Last)								2. Dete of Deet	h		3. Ti	me of Deeth	
Physicia: /Medica			JULIAN	0.	O. SALIK							AUGUST	25			:45	
	Exami		4e. Fecilify Neme (If not Institution,	give street and number)						4b. City, To	own, or Lo	ocation of Deeth	4c. Coun	ty of Deeth			
			GOOD SAMARI	TAN HOSPI	TAL					BALTI	MOR	E	BALT	IMORI	e C	CITY	
	Funerai Director		5. Social Security Number 218-30-5764	Sex 7. Age	89 (In yrs.	last birthd Yrs	Mo	Under 1	Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Day, SEP 17,	Year) 1909	9. Birthp Cour	ilace (S	itete or Foreign ovakia	
	D.		Usuel Residenca of Decedent											,	.001	Ovaleza	
	anyler show		10a. State 10b. County		10c. City	, Town o	r Locatio	n						1		ide City Limits	
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	₽ 6 ±	Director	10e. Street end Number					Of. Zip C	Code			10	g. Cltizen of	Whet Cour	et Country?		
	ath v	E	4000 N. Charl							1218				USA			
	tar death with the Marylen frems 23a or 28a-f show inst. must be notified at	Funeral	11. Mentel Stetus	12. Was Decedent E Armed Forces?		S. 1	13. Wes	Decede s, specif	nf of h	lispenic Or en, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		eck, White,		an,	
21215-0020	rall, or	by	1 Never Merried 200 Married	1 ∑ Yes 2 ☐ N If Yes, Give Year or Dates:	ь 1942-	-45	1 ☐ Yes 2 ☐ No Specify:							//y: Wh			
2	72 h	ete	15. Decedent's (Specify only highest)	Education arede completed)		16a. De	ecedent's	s Usuel of work	Occup	ation during mos	t of work	ina	6b. Kind of	Business/Inc	dustry		
121	s 1 and 2 should be filed within 72 hr if Health and Mental Hygiene. Item 27 is marked other than "netun other traumatic event, tha Medical	Completed	Elementery/Secondary (0-12)	+)	lif	e. DO N	kind of work done during most of working NOT use retired)										
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Maryland	12 st h and ls n reun		19a. Informent's Neme/Relationship			1.	9b. Mailing Address (Street and Number					-		-			
	s 1 and 2 of Health item 27 l		Felicia Salik 20e. Method of Disposition	/Wlie	anh D			N. Charles Street,									
O	Peges nent of I ant: If ite		1 Burial 2 Cremetion 3	□Removel from State	200. F	ametery,	cremetor	ry or oth	er pla	ce)	Į.	Dete 2	Oc. Location	- City or 10	wn, Ste	ite	
Ë	t. Pe tmer tant:		4 Donetion 5 Other (Specify) Metro Crematory, Inc. 8/26/99 Baltimore											more,	MD		
Baltimore,	permit. Pege Department of Important: If i any injury or once.		21. Signeture of Eurorel Service Licensee Cremation Society of MD, Inc. Edward A. Gregorchik 22. Name end Address of Fecility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, M														
	40240		Edward A.	Gregorchil	k	_	299	Fr	ede	erick	Ro	ad Balt	imor	e. MI	2	1228	
	Physician		23a. Pert1. Enter the disease, or co shock, or heert feilure. List on	mbliedions thet caused ly one ceuse on each lin	the deeth	. Do not	enter the	e mode	of dyir	ng, such es	cardiac	or respiratory erre	st,		Interve	ximete el Between	
S.			Immediate Cause (Finel disease or condition SEPTICEMIA											end Deeth			
/Medical Examiner														21	WEEKS		
		<u>.</u>	resulting In deeth)		Due to (or	es e con	sequenc	ca of):						1			
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5	at an	lon	1 Maturel 5 ☐ Pending	28e. Date of Injun (Month, Day	Year)	28b. Tim Injur	ry		Wor			28d. Describe how injury occurred					
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	ours ours eral filled		29e. Certifier 19 Certifying I	Phyaician: To the best of	f my knou	dedge de	aeth occi	urred et	the tir	no dete en	d place	and due to the co	uso(s) and m		hatad		
	To the Hospital or Attend within 24 hours efter deet! To the Funeral Director: completaly filled in by the	edicai	(Check only 2 Medical Ex-	aminer: On the basis of end menner stel	examineti	on end/or	r investig	gation, in	n my o	pinion, dee	th occurr	red et the time, de	te end plece	, end due to	the cal	use(s)	
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	Registr		AUG 2 6 19		a	19.	1	OBs.	K								



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Amended Item#8 perFH G774 8/26/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** PHANEEL Month P DE LO NES /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner altimore CHURCH HOSPITAZ 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 24 Hrs. **Funeral** 9. Birthpiece (State or Foreign 1□M 200 F Months Days Hours Odo 34 509 Usual Residence of Decedent Yrs Director 10a. State 10d. Inside City Limits Director TEMES 2 No YOY 10f. Zip Code 10g. Citizen of What Country? 8 Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0020 "natural", or 1 Yes No Completed by 3 ₩idowed 4 Divorced Specify: er than "natura", the Medical I 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 儿也 7 is marked other traumatic event, t Baltimore, Maryland 17. Father's Name (First Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Frank Towe CE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Attorne Ma. 20c. Location - City or Town, State 20b. Place oi Disposition (Name of cametery, cramatory or other place) Health e or other t 20e. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Depertment of important: If any injury or once 4 ☐ Donation 5 ☐ Other (Specify) rematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2.9 Broods the trace sease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or hear miliure. List only one ceuse on each line. Physician /Medical Immediate Cause (Finai disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 10 Yes 2 □ No 3 Probably 4 Unknown Records, þ Completed 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Wes en eutopsy performed? this certificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: Within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 4 Homicide Ecritifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of order who completed ceuse of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

AUG26

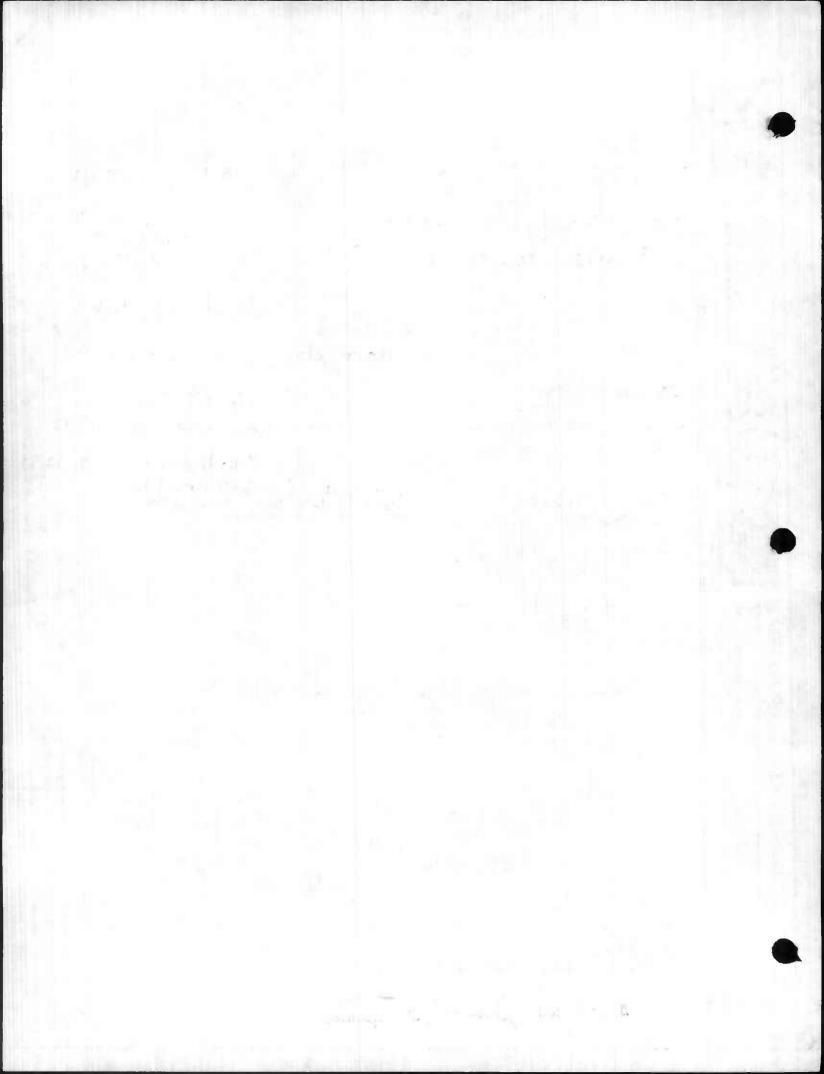
32. Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Month **Physician** Scovens -21,1999 June /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BAHMORES (If Under 24 Hrs. 8. De JOHNS HOPKINS 7. Age (In yrs. lest birthdey) 144 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2**□**F Days Months Hours Rechard Yrs 218-60-542 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner mast be notified at 1 Yes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Funeral ster 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece American Indian. 11. Marital Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiena. 2 **□ N**0 1 Never Merried 2 Married 1 Yes Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: py 3 Widowed 4 Divorced Year or Dates: Lack Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 112h memoker 17. Father's Name (First, Middle, Last) Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked oth any Injury or other treumatic even Be 2 James unner orethy 75U20V 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) Chatterd 4620 21206 20c. Location - City or Town, State 20110 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 1 Burial 2 □ Cremetion 3 Removal from State Beltimore, Maryland lemeter 4 ☐ Donetion 5 ☐ Other (Specify) 0 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Horre & Services Miller Balto 639 N. Boadway 23a. Part. Entry of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or hard failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical tmmediate Cause (Finel H-potension houts disease or condition resulting in deeth) **Examiner** Due to (or es e consequence ot): Examiner Ventricular Failure siclan and burial-transit requires that the death certificate be executed Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): Hypertension ulmonary Box 68760. Physician/Medical Due to (or es e consequenca of): 88 signed by the a P.O. Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings evallable prior to completion of cause of deeth? pluode 24a. Wes an autopsy performed? The law r page 2 12 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: Be 25. Was case reterred to medical 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Lactifying Phyatcian: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier completely (Check only one) within 2 ş 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier ead Bruce MD August 21, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Bruse Baltimore MD 21287 600 M. Wolfe Street Tower 110 AUG26" 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Year 1999 Wilhelmina Simons August 21, 12:25pm 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Catonsville Catonsville If Under 1 Yeer If Under 24 Hrs. 8. Dele of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1 M 2 TXF Sept. Yrs. 1904 219-20-8057 94 Maryland Usuel Residence of Decedent 10e. Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2KINO Maryland Howard Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6636 Washington Blvd. TRLR #106 21227 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Unknown Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Carl Lanehart Unknown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 6636 Washington Blvd.TRLR#106 Baltimore, MD 21227 Annette Simons/Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 8/25/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 roma ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or sent failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in death) to (or es e consequ Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e cons Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ₺ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA 28d. Describe how injury occurred 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 PNaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide l 🗠 Certifying Phyelcfan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as steted 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29h. Shnature ar 29c. License number 29d. Dete signed (Month, Dey, Year) eath (Item 23a) (Type, Print)

20 N. Rolling Rd

State Registrar

Physician

/Medical

Examiner

Director

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Health and Mental Hygiane. The important: If term 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, its feacing Examines must be notified as

Physician /Medical

Examiner

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To the Hospital or Attending within 24 hours effer deeth. To the Funeral Director: After

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32. Registrer's Signeture

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Ellen E. Schroeder 4b. City, Town, or Location of Deeth 48 Fecility Neme (If not Institution, give street end number) 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Oct. 19 1917 5. Sociel Security Number 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) 1□M 2AF Months Deys Hours Min 217-09-9165 81 Yrs. Maryland Usuei Residenca of Decadent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits TX Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2053 Whistler Avenue 21230 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Merried 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buelness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Pharmacy 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Lyman Cato Howe Mary Ellen McHugh 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Eileen M. Tynan 5811 Oakland Rd. Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State New Cathedral Cemetery 8-27-1999 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Nuneral Service Licensee 4107 Wilkens Ave. Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, of heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Final diseese or condition resulting In deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 3 Probably 1 Yes 2 No 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 | Nursing Home 5 | Residence & Hother (Specify) | DSM CQ 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Tima of 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

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Division of Vital Records, P.O. Box 68760,

Physician

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Is marked other than "natural", or ite

permit. Pages 1 end 2 st Department of Health end Important: If Item 27 Is n any injury or other traun

Physician /Medical

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29e. Certifier

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State Registrar

29b. Signeture end title of certifier

nd, address of person who completed cause of death (Item 23e) (Type, Print)

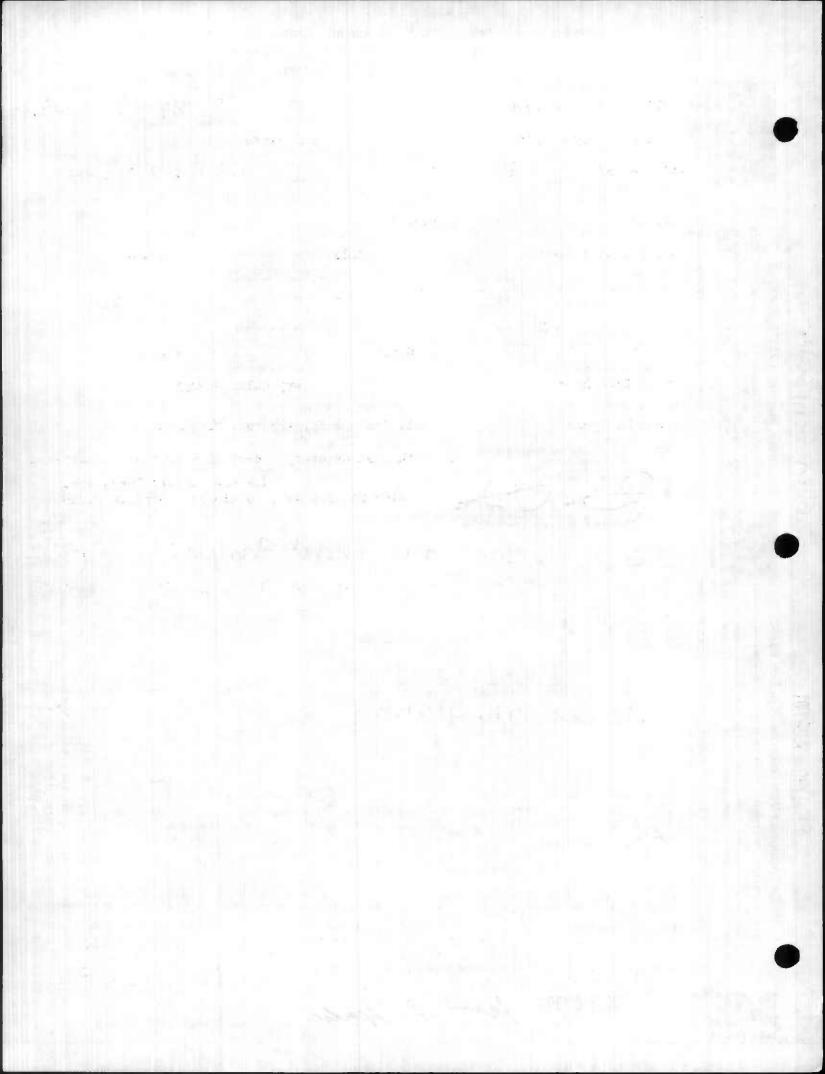
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🄂 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

29d. Date signed (Month, Dey, Year)

32 Aegistrer's Signeture



cords, P.O. Box 68760, requires that the death certificate be executed BY STATES.		
Box 68		Phys /Me Exa
	Вох	equires that the death certificate be asscuted

		Department of	Health and Ment	tal Hygiene	26700				
		Certificate of		Reg. No.	20190				
		Salomo	- A	Month Day	Year 3. Time of Death 999 1207PM				
a Facility Nama (If not institution, giva	street and number)								
		Link de 1 M Cheshon 4 Man	Easton		9. Birthplace (State or Foreign				
222-20-1246 10 M 218F 82 Yrs. Months Days Hours Min. (Month, Day, Year) 1-27-17									
Oa. Stata 10b. County	10c. City, To	own or Location			10d. Inside City Limits				
	INE D			1 ØŶes 2 ☐ No					
0e. Street and Number	First Street	2+ 101. Zip Code			0g. Citizen of What Country? USA				
1. Marrital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 Yas, 2 No If Yas, Give Yaar or Datas:	If Yes, specify Cu	ban, Mexican, Puerto Ricar	n, atc.) Blac	Race - American Indian, Black, White, etc.				
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7. Father's Nama (First, Middla, Last)	UNE BENT	ford			a)				
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Oa. Mathod of Disposition	20b. Place	of Disposition (Nama of	De	71	City or Town, Stata				
	emoval from Stata	itary, crematory or other p	lace)						
21. Signature of Finarai Sarvice License	DIRECTOR			2 0	. 114				
Jemany//	conse				Approximate				
mmediata Causa (Final disaasa or condition asulting in death)	4	y embolis a consequence of):	u		triterval Between Onset and Death				
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art ii. Other significant conditions con	tributing to death but not resultin	g in the underlying cause (given in Part I.	23b. Did tobecco use co	ntribute to the cause of death?				
coronary artery	desease			1 Yes 2 No	3 Probably Unknown				
0				24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion of cause of death?				
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1 Yas 2 No	1 Inpatient 2 KERV	Outpatient 3LI DOX	4 LI Nursing Homa						
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Pga. Cartifiar (Check only one) 1 Certifying Phys 2 Medical Examin	ver: On the basis of axamination	ige, death occurred at the and/or investigation, in my	time, data and place, and d opinion, death occurred at	lue to the cause(s) and ma tha tima, data and place,	inner as stated. and due to the cause(s)				
9b. Signalura and titla of certifiar	ero marko stateo.	29c. Lice	nse number	29d. Data signe	d (Month, Day, Year)				
matthe 1.1	asika MD	D	52251	08/22	199				
Nama and address of person who co	mpleted causa of death (Item 23	a) (Type, Print) Mem	orial i	Hospital					
11. Data liled (Month, Day, Year) AUG 2 6 199		B. Span	ls .	1	100				
	Recility Nama (If not institution, giva: The Memorial Ho Social Security Number 6. San 22-20-/346 1 Sual Rasidance of Decedant Oa. Stata 10b. County MD CAROL Oe. Street and Number 1. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced (Specify only highast grade Elementary/Secondary (0-12) 27. Fathar's Nama (First, Middla, Last) 19a. Informani's Name/Raietionship (Ty CHAM J. Robius Oa. Mathod of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Othar (Specify) 21. Signature of Fanaral Sarvice License 223a. Part1. Entar tha disbasa, or complicated Causa (Final diseasa or condition as ulting in death) 23a. Part1. Entar tha disbasa, or complicated Causa (Final diseasa or condition as ulting in death) 24. Signature of Fanaral Sarvice License 25a. Part1. Entar tha disbasa, or complicated Causa (Final diseasa or injury hat initiated evants as uniting in death) 25a. Cartifier 1 Accidant 3 Suicide 6 Could not be datarmined 26a. Cartifier 1 Certifying Physical	Decedent's Nama (First, Middla, Last) ROBERTA BEONFORD a Facility Nama (If not institution, giva street and number) The Memorial Hospital Social Security Number (Social Security Number (222-20-/346 1 M 207 82 1 N 20	Certificate Oi. Decedent's Nama (First, Middle, Last) Roberth Bedford Salomo. a Facility Nama (If not institution, gives street and number) The Memorial Hospital. Social Security Number 6. Sar 1 Age (in yrs. last birthday) 1 Funder 1 Yes. Social Security Number 7. Age (in yrs. last birthday) 2 Age (in yrs. last birthday) 1 Funder 1 Yes. Social Security Number 1 Control 1 Age (in yrs. last birthday) 2 Age (in yrs. last birthday) 2 Age (in yrs. last birthday) 1 Funder 1 Yes. Social Security Number 6. Sar 7. Age (in yrs. last birthday) 1 Funder 1 Yes. Social Security Number 7. Age (in yrs. last birthday) 1 Funder 1 Yes. Social Security Number 1 Control 1 Contro	Certificate of Death Concedent's Nama (First, Middin, Lats) Robert Robert Bed Ford Salomon a Facility Nama (first in distribution, give street and number) The Memorial Hospital Social Security Number As Social Security Number Number or Number of Number of Number or Number or Number or Number of Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number or Number o	December Name Grat, Middle, Last) The Memor I al. Hospital The Memor I al. Hospital The Memor I al. Hospital The Control Society Name (if not institution, pive state and number) The Memor I al. Hospital The Memor I al. Hospital The Memor I al. Hospital The Society Name (if not institution) The Memor I al. Hospital The Memor I al. Hospital The Memor I al. Hospital The Society Name (if not institution) The Memor I al. Hospital The Memor I al. H				

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State Registrar

Dennis 31. Date filed (Month, Day, Year) AUG 2 6

29b. Signature and title of certifier

nutero 32. Registrer's Signature

trufe 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1999

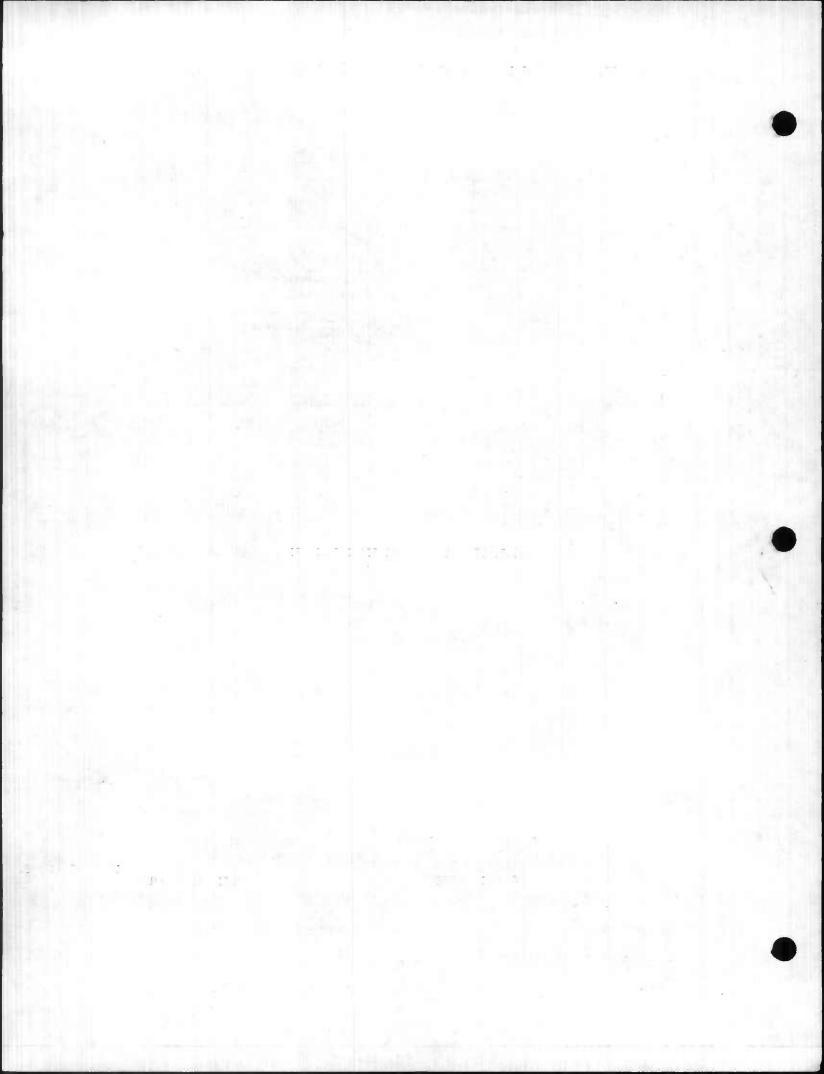
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29c. License number

OCME.

29d. Date signed (Month, Day, Year)

AUGUST 21, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Yoshio Sakaue August 10 1999 21:50 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months: 319-26-1789 M 2DF Hours 81 Director April 25,1918 Califorina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Virginia | Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 United States items 23a 1600 South Eads Street Funeral Apt. 1111 death 22202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: Asian by 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiens. other than "n Elementery/Secondery (0-12) Coilege (1-4or 5+) Pages 1 and 2 should be filled wi tment of Health and Mental Hygien tant: If item 27 is merked other th Jury or other traumatic avant, the 12 civil service director 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Sokuma Sakaue Naru Hori 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Miyoko Sakaue - wife 1600 South Eads Street #1111 N, Arlington, Va 22202 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Everly Wheatley Crematory 8/16/99 Alexandria, Virginia 21. Signeture Puneral Service Licenses 22 Name and Address of Facility Everly Colonial Funeral Home 6161 Leesburg Pike Falls Church, Virginia 22044 23a. Part1. Enter the disease, or complications that quised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on (as h line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Respiratory Failure 3 days **Examiner** Due to (or as a consequence of): Examiner Pneumonia 2 days physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 3 years Box 68760 Lymphoma Physician/Medical Due to (or es a consequence of): attending p 950 P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Gastrointestinal Bleed Records, ò The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 21 No 1 Yes 2 No 1□ Yes Division of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2♥ No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel
2 Accident 5 Pending 1 TYes 2 No investigetion 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier To the Hosp w hin 24 hos To the Fune completely fi (Check only one 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Ankum D0053335 NO 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) William Matsui, MD 600 N. Wolfe St. Baltimore, MD

Registrar

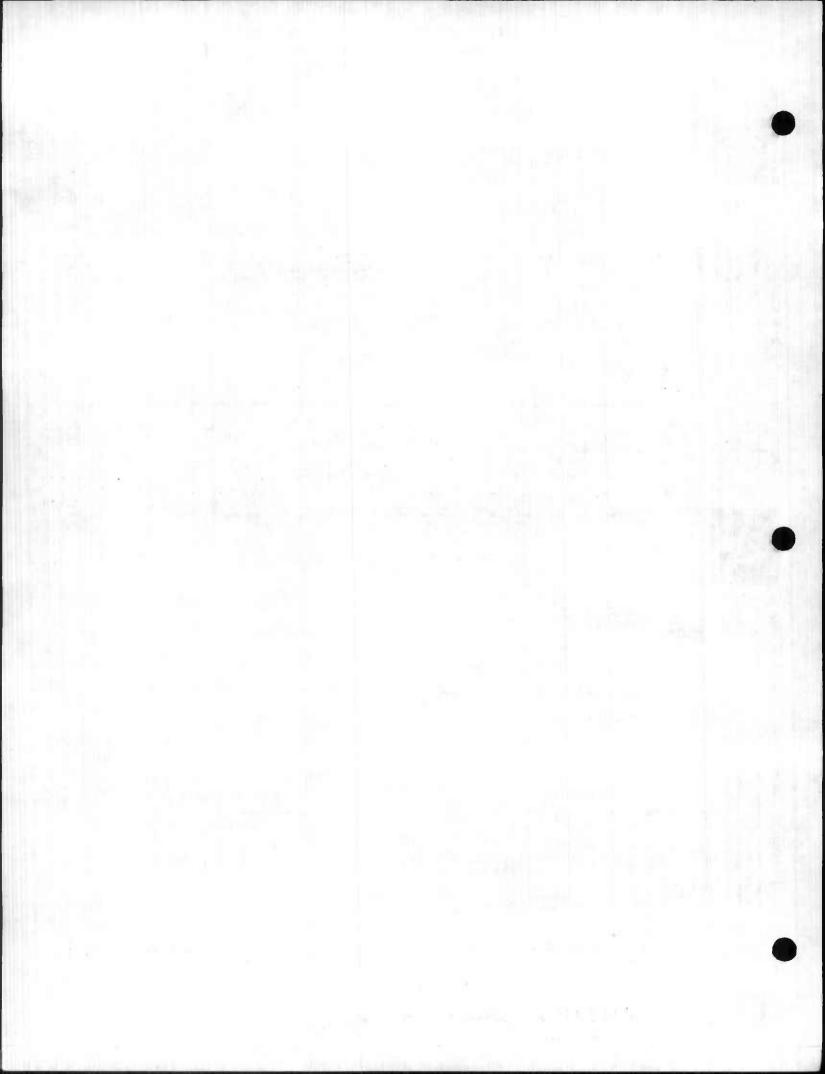
State

AUG 2 6 1999 **DHMH 16 Rev 6/95**

31. Dete filed (Month, Dey, Year)

32. Figgistrar's Signature

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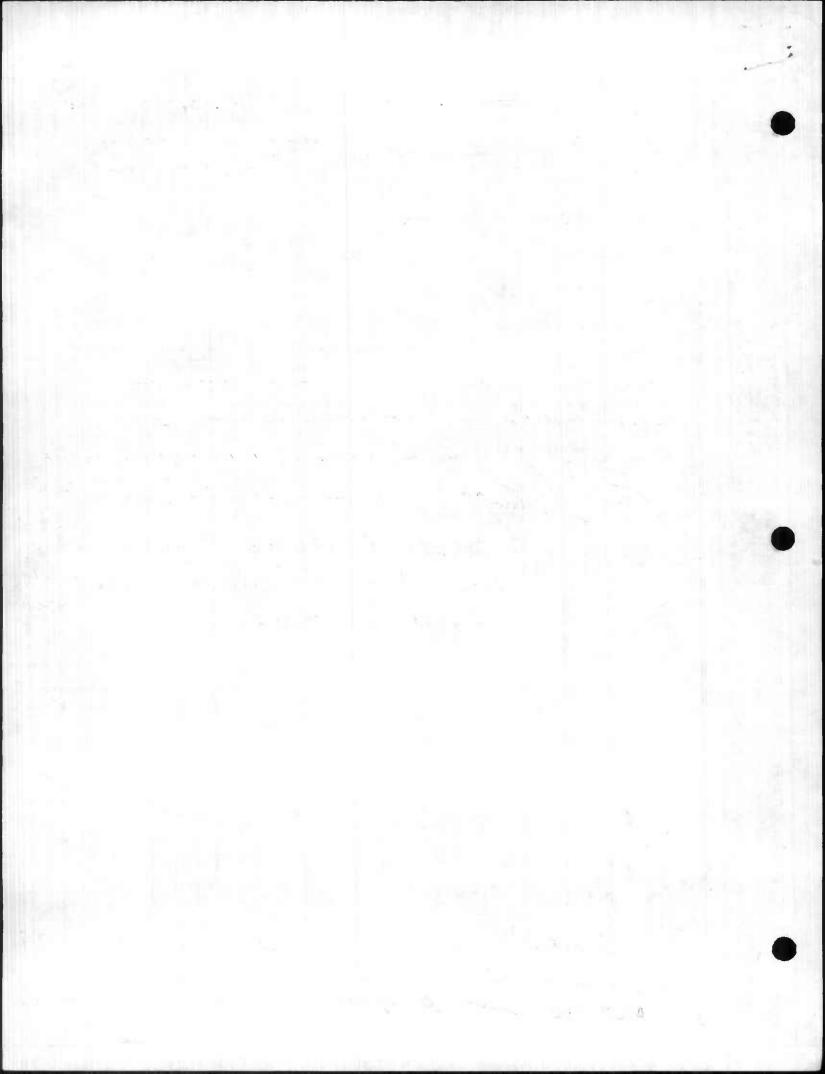


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dale of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death 23, 1999 Month **Physician** Schultz Gertrude E. Aug. 6:20 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1□ M 2□ F Yrs 214-20-7548 Director Jan. 5, 1909 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo 28a-f Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Dellsway 1513 Road 21286 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc filed within 72 hours after 1 ☐ Yas 2 ☐ No If Yas, Give 1 Nevar Married 2 Married 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☑ Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 8 yrs. Wire Inspector Western Electric 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental James Joseph McGuire Jennie Lillian Gerlach 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) important: If Item 27 is any injury or other trau Mrs. M. Joan Popoli/Daughter 1513 Dellsway Road Towson, Maryland 21286 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata ty Burial 2 □ Cramation 3 □ Ramoval from State
4 □ Donation 5 □ Other (Specify) Department Most Holy Redeemer Cem. 8/25/99 Baltimore, Maryland 21. Signature of Puneral Service Licen 22. Nama and Addrass of Facility 1050 York Road ang Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Entar tha disaas of or shock, or haart failure. used the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, **Physician** Myo cardial Infanción Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical Examiner Cardiovascular Tixes more thin Examiner sician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or Injury that initiated avents rasulting In death) Last physician s the burial Box 68760, Physician/Medicai Dua to (or as a consequance of) 88 980 signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? page 2 should Completed completion of cause of death? 1 ☐ Yas 2 1 NO Division of Vital Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Yas No
27. Menger of Death
1 Natural
2 | American Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatiani 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending invastigetion or Attending 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29a. Certifier Medical completely (Check only one) Fo the F Tothe 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signatura and titla of certifian D 3064-1 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Back RIVER NICK ROAD 201-109 Sabapathi 31. Date filed (Month, Dey, Year) AUG 2 6 1999 32. Ragistrar's Signature State Registrar



SHARON L. SUGDEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of M

laryland /	Department	of Health	and	Mental	Hygier

	1. Decedent's Nama	(First,	Middle,	Last)
Physician /Medical	Sharon		L.	

Examine

Certificate of Death

2. Deta of Deeth Month

Des

3. Tima of Death

Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certification: To Be Completed by Physician/Medical Exan within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral

Division of Vitai Records, P.O. Box 68760,

Sharon L.	Sugder	n				AUGUST	23, 1	999	5:42P.M.
4a Fecility Name (If not institution, git	ra street and number)		-	4b. (City, Town, o	r Location of Deet			1 mi elle
JOHNS HOPKINS HOS	PITAL			R	ALTIMO	RE	N/A		
5. Social Security Number 6. 5	Sex 7. Ag	e (In yrs. last birthda	(y) If Under 1	Year If	Under 24 Hi	s. 8. Data of Bir			aca (State or Foreig
216-96-8005	1□M 2⊠F	35 Yrs.	Months I	Days I	Hours Mi	May 28		MD	aca (State or Foreig ry)
Usuat Residence of Decedent		33				May 20	1904	FID	
10a. State 10b. County		10c. City, Town or	Location				-	10	d. Insida City Limit
MD N/A		Baltim	ore						1⊠Yes 2□N
10e. Street and Number			10f. Zip C	ode		1	10g. Citizen of	What Count	n/2
3302 Leverton	λτιο							William Count	191
		5		224	-1-0-1-1-0	/O 7 V	USA	Ai	a tadiaa
11. Merital Status	12. Was Decedent Armed Forces?		If Yes, specify	y Cuban, I	Mexican, Pue	Specify Yes or No orto Rican, etc.)		ce - America ck, White, e	
1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:	No	1□ Yes 2 %	No S	pecify:		Specif	y: Whi	ite
15. Decedent's E	ducation	16a. Dec	cedent's Usual (ive kind of work a. DO NOT use	Occupatio	n	and in a	16b. Kind of B	usiness/Ind	ustry
(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5			retired)	ng most or w	Orking			
9	0011090(1.10.10	" Cas	hier				Fast	Food	
17. Father's Name (First, Middle, Last)			18	. Mother's N	eme (First, Middle	, Maiden Sumer	me)	
Robert J. Sug	den Sr.				Fran	ces L.	Gregor	У	
19a. Informant's Neme/Relationship (Type, Print)	19b. Me	ailing Address (S	Street and	Number or I	Rural Route Numb	er. City or Town	State, Zio	Code)
Richard E. Su			19 Har				timore		
20a. Method of Disposition	guerr / sc	20h Place of Dis	nosition (Name	of		Dete	20c. Location		
1 Burial 2 ☐ Cremetion 3 ☐	Removel from State	cemetery, c	rematory or other	er place)		Aug 28	LOG. COGGIOT	Ony or To	m, otota
4 □ Donation 5 □ Other (Special	(y)	Oak La				1999	Balti		
21. Signeture of Funeral Service Lice	nsee	01	22. Name and	Address of ETTV	Fune	eral Hon	ne of I	Dunda	lk
Chithau C	Consul	011				Point F		222	
23a. Part1. Enter the dismon, or com shock, or heart failure. List only	plications that caused	the death. Do not e							Approximate
shock, or heart failure. List only	one cause on each life	ne. ()							Interval Between Onset end Death
Immediate Cause (Finet	11 1.	In /							
disease or condition resulting in death)	· / lat	tyle h	Julus	•					
	·	De 10 (or es a cons	sequence of):						
	b							í	
Sequentially list conditions,		Due to (or as a cons	sequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury									
that initiated events resulting in death) Last	G	Due to (or as a cons	equence of):						
	d							1	
Pert II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cau	ise given i	n Pert I.	23b. Dld	1obacco una co	ontribute 10	the cause of death
	•						Yes 2 No		11
						-	100 2010		X
						24a. Wes	en autopsy		re autopsy findings
						perfe	omed?	con	ilable prior to apletion of cause
								of d	leath?
						1/2	Yes 2□No	100	Yes 2□ No
25. Was case referred to medical examiner?				26	6. Place of D	eeth (Check only	one)		
XXYes 2□ No	Hospitat: 1 ☐ Inpatie	ont 2DER/Outpat	ient 3 DOA	Other:	4 Nursing	Home 5 ☐ Resi	dence 6 Otl	her (Specify)
27. Manner of Death	28a. Date of Injui	ry 28b. Time	of 280	tnjury at Work?	0.	28d. Describe.	how injury occu	rred	1200
1 Netural 5 Pending 2 Accident investigatio		12	DLMb	1 Yes		July	tparte	ge 90	reach in
3 Suicide 6 □ Could not b	288. Philosof Inti	ury - At home, ferm,	street, fectory, o	office	1	28f. Location (Street and Num	ber of Rural	Royle Number
4 Homicide	building, etc	c. (Specify)	0			City or To	wn, Stete) 17	to Place	1 yeth
29e. Certifier 1☐ Certifying Pt	nysician: To the best of	of my knowledge de	ath occurred	the time	date and ols	ne and due to the	causale) and	Anner so at	ated.
	niner: On the basis of and manner sta	examination and/or							
29b. Signature and title of certifier	un of the whole ste	mod.	20c 1	License nu	ımber		29d. Date signe	ad (Month F	lay Year)
organisa and this of osterol			200. 6				-na nata signi	- a freemanters P	-/1 /

State Registrar

31. Data filed (Month, Day, Year) AUG 2 6 1999

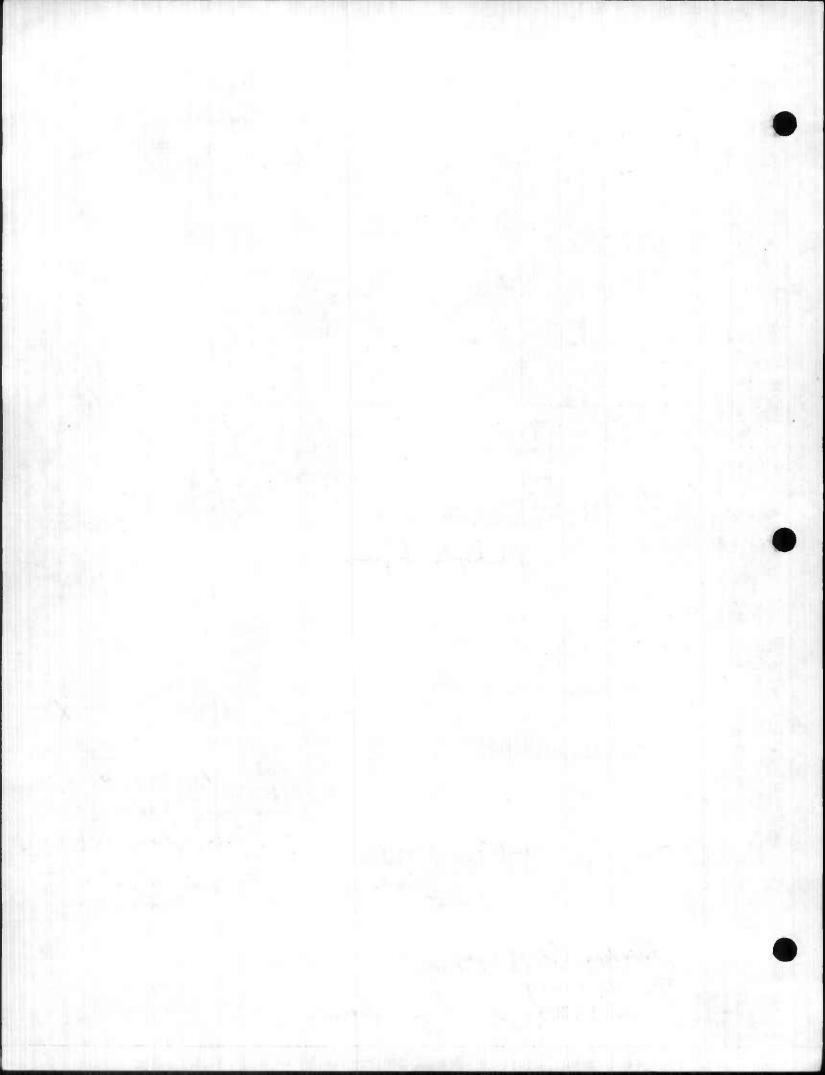
32. Begistrar's Signature

cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

AUGUST 24,1999



State of Maryland / Department of Health and Mental Hygiene

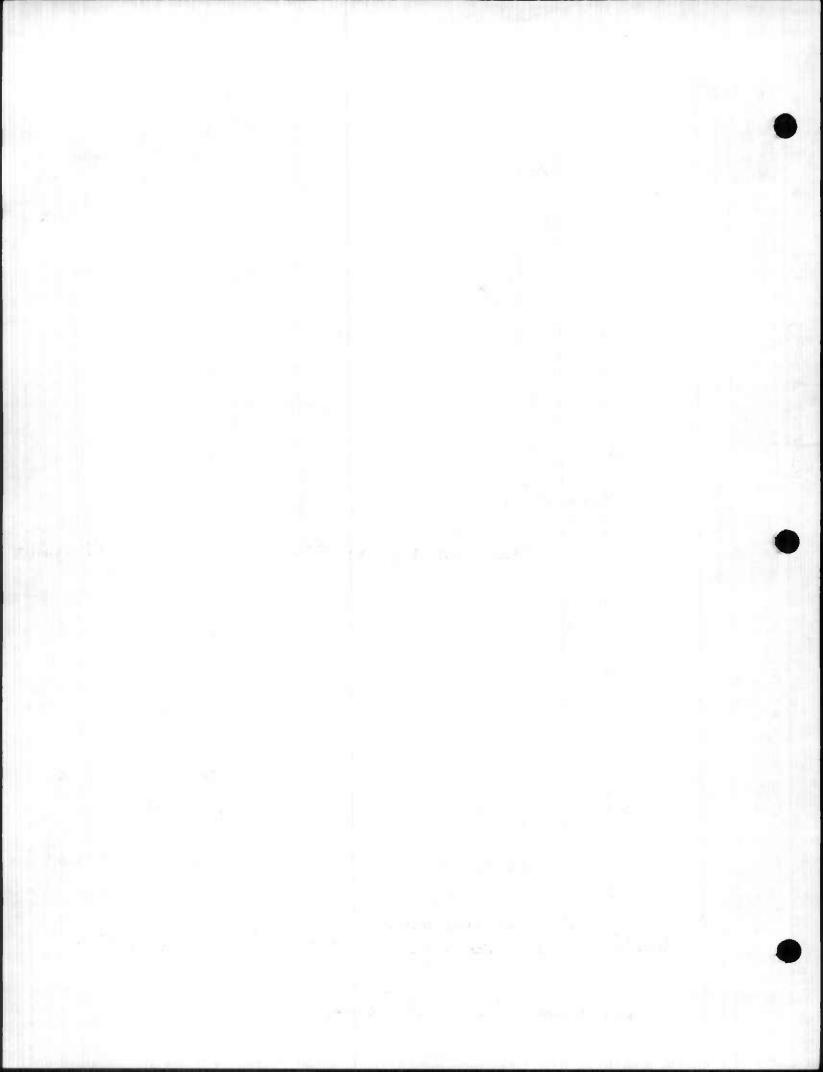
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert D. Suggs 8:30 AM August 23, 1999 /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** 9256 Red Cart Ct. Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mache Dave Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□F Yrs. Director 48 527-82-1837 June 10, 1951 Arizona Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show of fleath and Mental Hygiene. If flem 27 is marked other than "natural", or flems 23a or 28a-f show other traumstic event, the Medical Examiner must be no thed at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21045 9256 Red Cart Ct. U.S.A. Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Horse Racing Elementary/Secondery (0-12) College (1-4or 5+) Jockey Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecil V. Suggs Rita Chisulm 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e Important: If Item 27 is eny Injury or other tra 9256 Red Cart Ct. Columbia, Maryland 21045 Ms. Linda Ann Robinson Wife 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 08/25/99 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 & Tho 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical gomo concinom s **Examiner** Due to (or as a consequence of): Examiner ician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitiated events resulting In death) Last Due to (or es e consequenca of) physician a Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) 88 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 s 1 ☐ Yes 2 No or Attending Physician: funeral director. 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No deeth. 2 Accident 24 hours efter deet Funeral Director: 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature DIRECTOR, DIVISION 29c. License number 29d. Date signed (Month, Dey, Year) OF MEDICAL ONCOLOGY 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Donehower, Ross C., MD FACP 600 North Wolfe St. Baltimore, MD 21287-8936 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

books

Registrar

AUG 26 1999

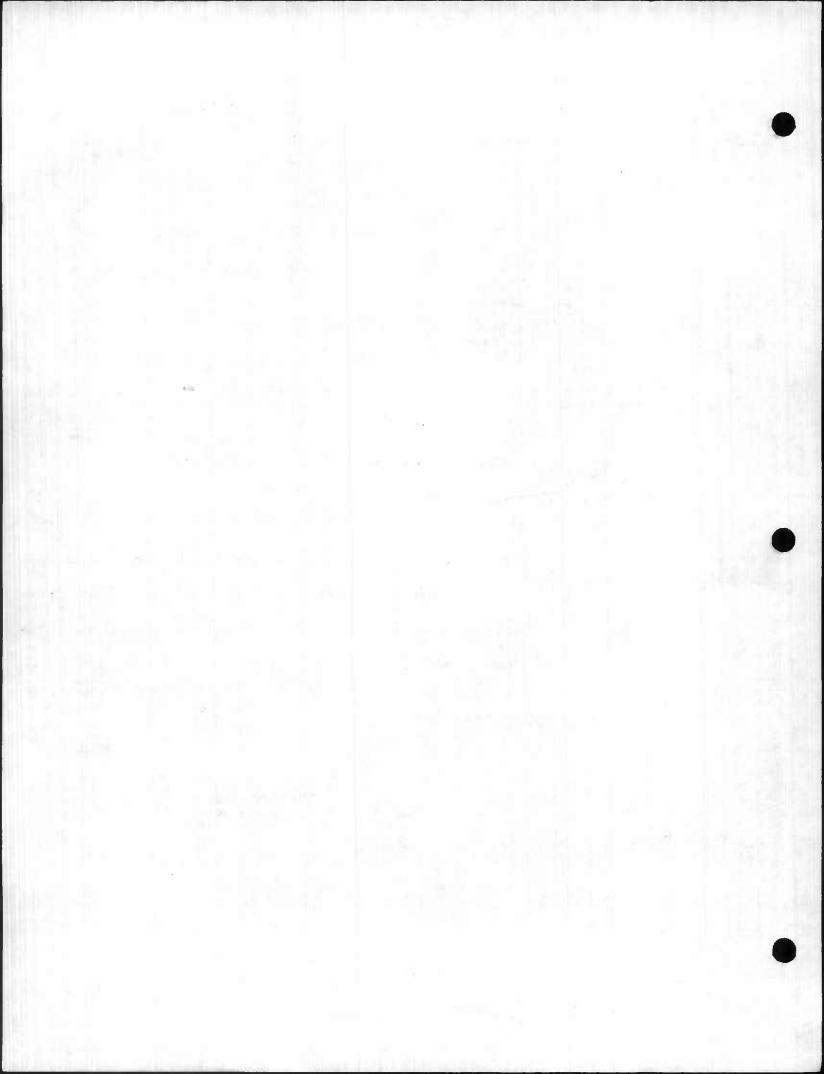


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Vivian Torney August 22, 1999 Anna 8:00am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 1222 Pine Heights Avenue If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan. 10, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Deys Months 1□M 2€ F 85 214-20-9885 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23s or 28s-f show 1 ▼ Yes 2 No Director Baltimore Maryland n/a 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21229 1222 Pine Heights Avenue USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than "natur treumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 10 0 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If them 27 is marked oth lury or other treumatic even Be Michael J. Moran Loretta Grimes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 174 Virginia Lane, Apt. L, Glen Burnie, Md. 21061 Richard E. Torney / Son 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Department of Important: If 4 □Donation 5 MOther (Specify) Entombment Loudon Park Mausoleum 8/27/99 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) PULMONARY DISEASE Examiner Examine CARDIDMYOPATHY The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot): physician s the burial Box 68760. ATRIAL YARBXYSMAD Physician/Medical Due to (or as e consequence of): BRONCH ITIS WIE for use Pert It. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 18 Yes 2 □ No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was cese referred to medicat exeminer? Be 26. Place of Deeth (Check only one) Hospitat: Other: 4 ☐ Nursing Home 5. Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Dey Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at After 5 Pending Investigetion 1. Netural 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29e. Cartifier 18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as attated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. (Check only one) Within 2 To the Sapano 29b. Signature and title of certifies 29c. Licensa number 29d. Date signed (Month, Day, Year) MARYLEND ATTENDING CARDIOLOGIST 00041711 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WILKENS AVENUE SLITE 300 BALTIMORE, MARYLAND 21229 N MO 344 37 Registrer's Signeture 3449 JONATHAN State

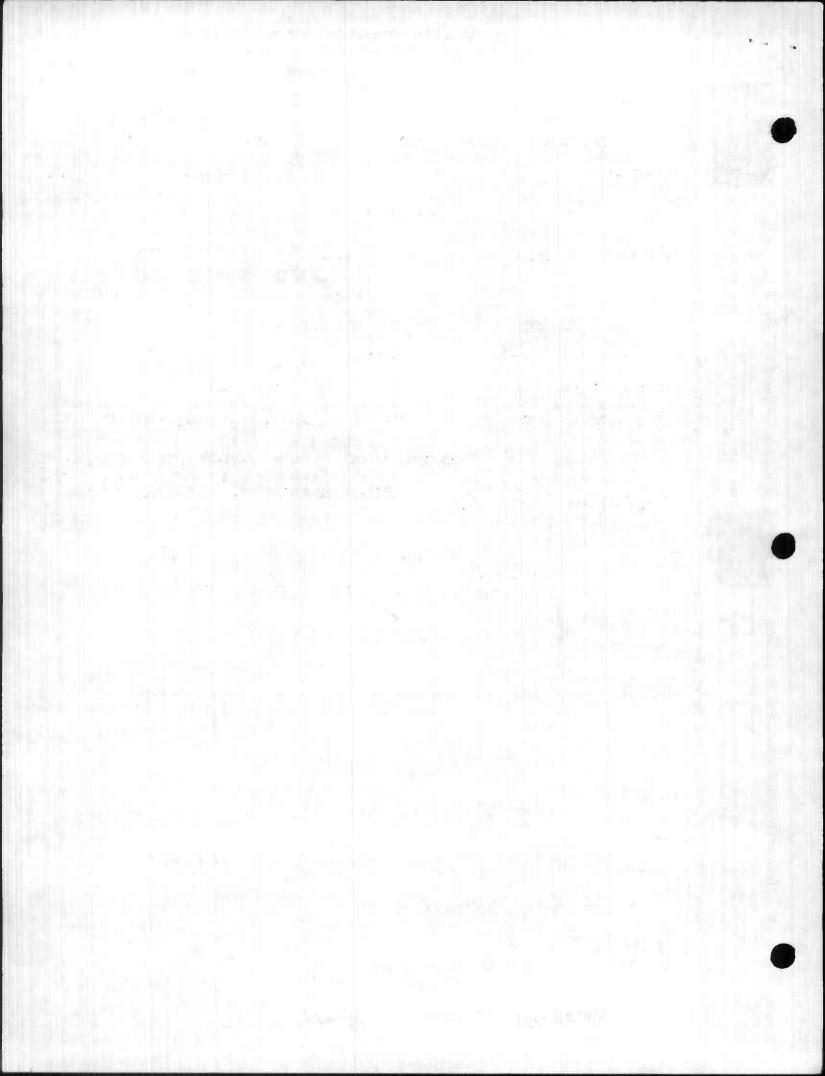
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State of Maryland / Department of Health and Mental Hygiene 9 2679

				Certific	ate of	Death		Reg. No.	6) 131
sician	Decedent's Nama (First, Middla, Las Charles 7	Thoma	2				2. Date of De Month	Day	Year 1999	3. Time of Death 7:38 A.M
dical niner 4	a Facility Nama (If not institution, give SANDTOWN/WINCHES	Location of Daatl	4c. County	- 1						
r	220-74-2103	ex 7. Age	e (In yrs. last bii 81	rthday) If Ur Yrs. Mont	hs Days			th y, Year) 17	9. Birthple Countr	MD.
1	Isual Residence of Decedent Oa. State 10b. County MD • N/A		10c. City, Tow BAL	m or Location					10	d. inside City Limits
ā	0e. Street and Number 201 WASHINGTON S	т.		10f.	Zip Code	31		10g. Citizen of V USA		у?
by Fur	Marital Status □ Navar Married 2 Married 3	12. Was Decedent Armed Forces? 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1			ecedent of specify Cults	Hispanic Origin? (S ban, Mexican, Puar Specify:	Specify Yes or No to Rican, atc.)	Blad	e - Americe ck, White, et :: BLAC	tc.
Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) —12—			Decedent's U (Give kind of life. DO NO DISAE	work done Tuse retire	during most of wo	rking	16b. Kind of B		istry
To Be C	7. Fathar's Nama (First, Middla, Last) CHARLES THOMAS						me (First, Middle) E GAINS	-		
	19a. informant's Name/Relationship (1 HILDA THOMAS (SIS	* .	198			GTON ST.				
2	0a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemete	of Disposition (ory, crematory ON FORE	or other pl		Date 8-31-99	20c. Location -		vn, State , MARYLAND
2	21. Signature of Funeral Service Licen	Builo	ue			ess of Facility VE	RNON BA	LEY FUN	ERAL	
Medical Examiner	disease or condition esulting in death) Sequentially list conditions, leny, leeding to immediate seuse. Enter Underlying Causa (Disease or Injury hat initiated events esulting in death) Last	b. Cord	Thm C Due to (or as a LOV OS Due to (or es e	consequence	reasi	2.				
Physician/	art II. Other significant conditions of	23b. Did tobacco use contribute to the cause of death?								
Completed by P							24a. Was	an autopsy ormed?	24b. Wer ava com	re autopsy findings ilable prior to apletion of cause leath?
	5. Wes cese referred to medical					26. Placa of De	ath (Check only		10	Yas 2 No
0	examiner? 1 Yas 2 No	Hospital: 1 ☐ Inpatia	nt 2 ER/O	utpatient 3	DOA	ther: 4 Nursing	Home 5 Res	dence 6 Oth	ner (Specify,)
	7. Manner of Death 1. Neturel 5 Pending 2 Accident investigation		ry Year) 28b.	Time of Injury M	28c. inj W 1[uryat ork? ⊒Yes 2 □ No	28d. Describe	how Injury occur	rred	
Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injubuilding, etc	ury - At home, fi c. (Specify)	arm, street, fa	ctory, office			Street and Numi wn, State)	ber or Rural	Route Number,
edical	(Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examinetion er		tion, In my	opinion, death occ		date and place,	and due to	the cause(s)
≥ 2	9b. Signeture and title of certifier	eal r	1.0		7 3	3912 7		S/2	6/99	7
3	0. Name and address of person who a		eath (item 23a) ÉuTa	(Type, Print)	Stree	1- Bay	limore	MD	212	01
State 8	1. Date filed (Month, Day, Year)	32. Registre	ar's Signature	, -	-,-					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death Facility Nama (If not institution, giva 4b. City, Town, or Location of Death Millennium | 5. Social Security Number mo .Ctr. ot 6. Sex 7. Aga (In yrs, last birthday) 9. Birthplace (Stata or Foreign Days -66-3626 100M 20 F Hours Usual Rasidanca of Decedent 10c. City, Town or Location 10a, Stata 10b. County 10d. Inside City Limits 1X Yas 2 No Vlaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? de 12. Was Decedant Ever in U.S. Armed Forcas? 1 Yes 2 No Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, etc 1 Yes 2 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highast grads completed) 16a. Decedant'a Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OV 17. Father's Nama (First, Middla, Last) 18 Mothar's Nama (First, Middle, Maiden Sumama) arence ocial worker 19a. Intormant's Name/Raletionship (Type, Print) 19b. Mailing Addrasa (Street, and Number of Rural Routa Number, City of Town, tendel de 20a. Method of Disposition 20b. Placa of Disposition (Name of camerary, crematory or other place) Data 20c. Location - City or Town, Stata 180 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Toseph L. Ry 21. Signature of Funeral Service Lipenses Joseph to ase, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory arrest, but a cause on each line. Balto Approximata Interval Between Onset and Death HUNTINGTON CHOREA Immediata Causa (Final diseasa or condition rasulting in deeth) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequenca of): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24e. Was an autopsy performed? complation of cause of death? 20 No 1 Yas 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work?

Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, 080 signed by the a page 2 this certificata funeral director, After 1 within 24 hours after death. To the Funeral Director: A tha filled in by

Physician /Medical

Examiner

Funeral Director

Completed by

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.

Intelligent 77 is marked other than "natural", or Heme 23e or 28e-f show any or other transities notified as

Department of Important: If any injury or

Physician

Examiner

/Medical

21215-0020

Baltimore, Maryland

25. Was casa ratarred to medical axaminar? 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 5 Pending investigation 1 Tyes 2 TNo 2 Accidant 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end title ot certifier

29d. Data signed (Month, Day, Year) 0/25/99

30. Nama and addraes of person who completed cause of death (Item 23a) (Type, Print) SILCET N' EUTAW 821 A. AHMED

State Registrar

Medical Certification: To

31. Date tiled (Month, Day, Year) 32. Registrar's Signatura

AUG 26

DHMH 16 Ray 6/95

Hospital

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle Last) 22 IDHNNIE 750 H 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death SECOURS BON SE BALTIMURE tospitA If Under 1 Year If Under 24 Hrs. 8. Dete of 8irth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 10 M 20 F 53 Yrs. 218-44-0490 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N☐ Yes 2☐ No Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3008 Edmondson Avenue 21223 U.S.A. 14. Rece - Amarican Indian. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merrled 1□Yes 2€ No Specify: Specify:Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Assembly Line Worker Noxell Factory 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ella Mae Sheppard John H. Brand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 3008 Edmondson Ave., Baltimore, Maryland 21223 Stacey Thomas / Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/27/99 Landsdowne, Maryland Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones Funeral Hm. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that claused the deeth shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 XNo 1 ☐ Yas 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde

Box 68760 Division of Vital Records. Attanding b

Physician

/Medical

Examiner

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Funeral

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Examiner

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Certification:

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29a. Certifier

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290. Signature

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiens. Important: If itsm 27 is marked other than "natural", or itsms 23a or 23a-f show any injury or other traumatic event, it a Medical Eventment must be notified an once.

Physician

/Medical **Examiner**

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Baltimore, Maryland 21215-0020

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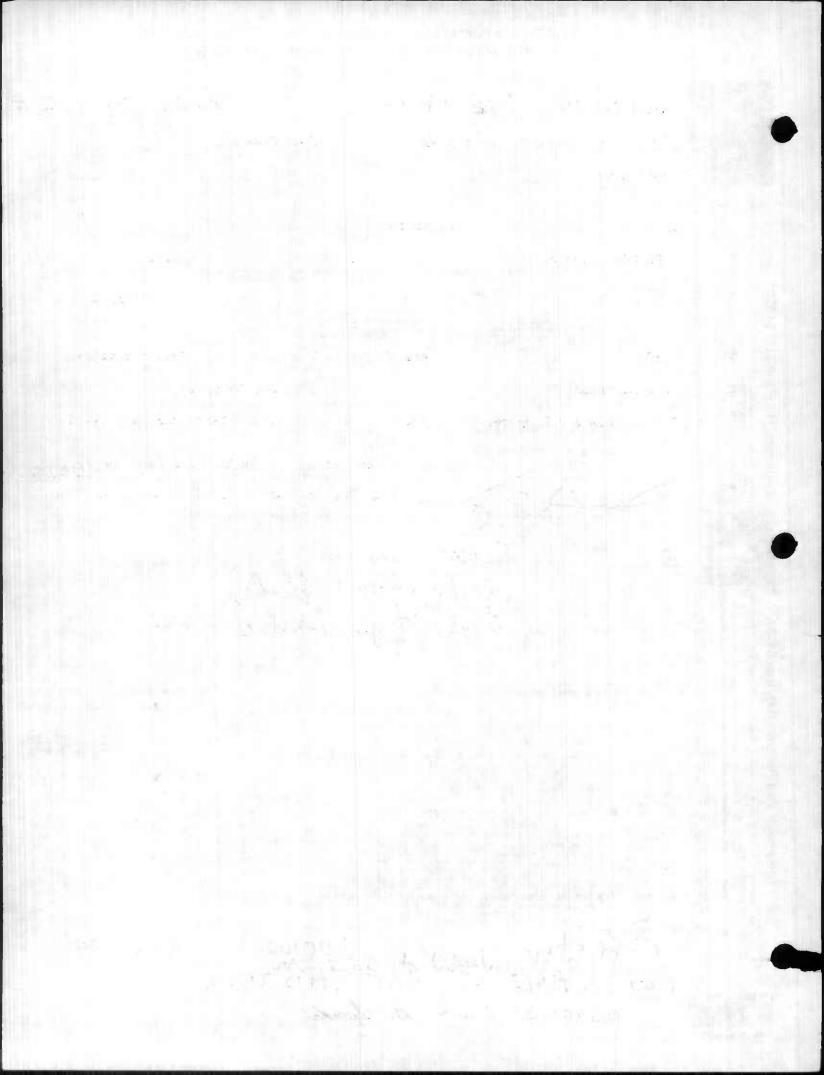
> State Registrar

31. Date filed (Month, Day, Year) AUG 26 1999

32. Registrar's Signature

108 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and menner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)



99-4826-005 UNK 99-183 asp Baltimore, Maryland 21215-0020

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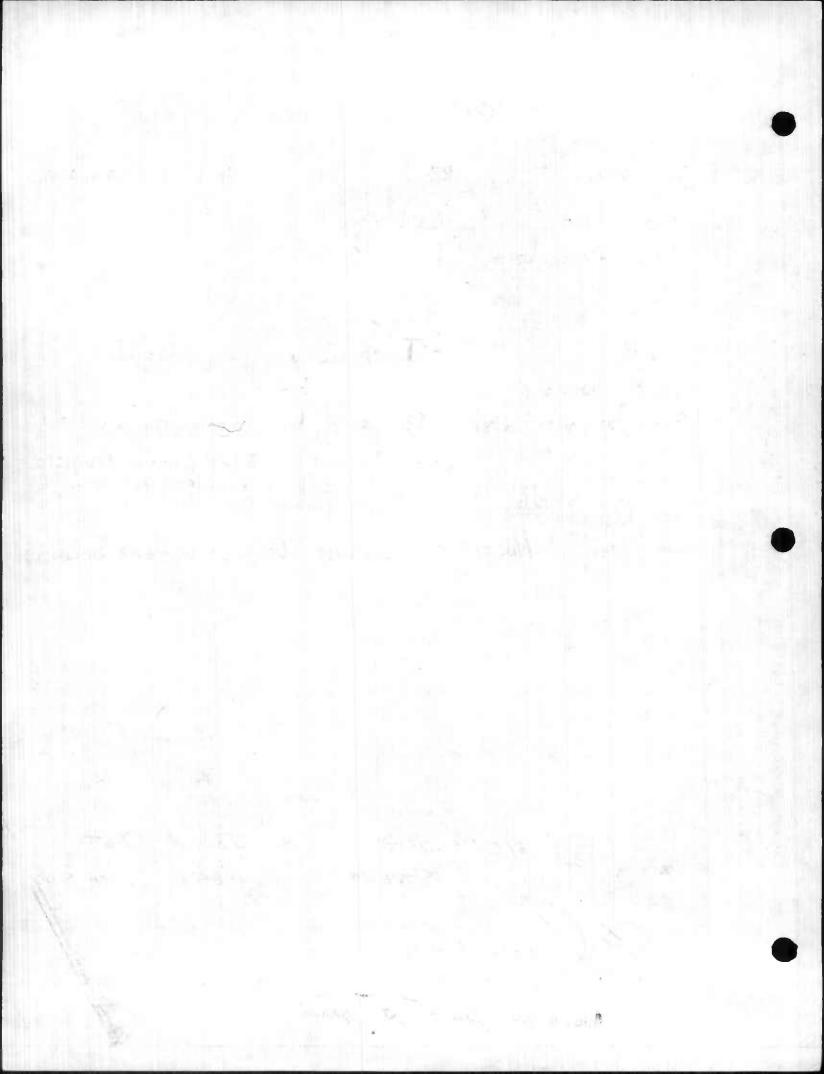
State of Maryland / Department of Health and Mental Hygiene

VELL WILLIAMS	Ce	rtificate of l	Death	Reg	g. No. 9	9 9	6800	
1. Decedent's Neme (First, Middle, Last)				2. Dete of Deeth Month		Voor	3. Tima of Deat	
Donnell	Williams			AUGUST	17 :	1999	2350	
4e Facility Name (If not institution, give st		4	lb. City, Town, or L	ocation of Death	4c. County	of Death		
1965 E. JOPPA RE),				BALT	IMORE		
5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day,	Year)	9. Birthpi	lece (State or Fo	
411-68-1650	28 Yrs.			4 3	7	Mar	-yland	
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Alu LM	Roll	20000					1 76s 2	
10e. Street and Number		10f. Zip Code		10	g. Citizen of V	Vhet Coun	trv?	
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1 Never Merried 2 Married	1 Yes 2 No	If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Bled	k, White,	etc.	
3 Widowed 4 Divorced	If Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify	B	Lack	
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15. Decedent's Educa (Specify only highest grade of Elementery/Secondery (0-12)	College (1-4or 5+)	DO NOT use retired	()	ii iy	2 -	-		
[14)	11	rick 1	river		17.4			
17. Father's Name (First, Middle, Last)			18. Mother's Nem	e (First, Middle, Mi	aiden Sumem	10)		
Mack William			6/0010	1760				
19e. Informant's Neme/Relationship (Type	, Print) 19b. Meili	ing Address (Street	and Number or Rui	al Route Number,	City or Town,	State, Zip	Code)	
Oloria Williams.	Molter 391	1 Deidle	Hite.	Maltimor	e Mari		21213	
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rec	- acomotory cro	metory or other plec	(e)		Oc. Location -	City or 10	wn, State	
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Jela 47/4	les. ii	39 N. An	rowhou	Batto Mo	1. 212			
23a. Part1. Enter the disease, or complice shock, or heat faire. List only one	itions thef ceused the deeth. Do not en ceuse on each line.	ter the mode of dyin	g, such as cardiac	or respiratory erres	st,		Approximete Interval Between	
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Immediate Cause (Finel disease or condition	MULTIPLE GO	UNSHO	7 WOW	NDSO	FHEI	4) 6	DECON!	
resulting in death)	Due to (or as a conse	quence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						ì		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or es a consec	quence of):						
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1 Netural 5 Pending investigation	/Moreth Charles Injune	28c. Injun Work		Toun	d	Tho	+	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, ferm, str			28f. Location (Stre	eet and Numb	er or Rura	I Route Number	
4 Homicide	building etc. (Specify)	EET		City or Town,	State)	999	A RD	
29a. Certifier 1 Certifying Physic	an: To the best of my knowledge, deet		ne, date and place,		use(s) and ma	* 1 .		
	On the basis of examinetion and/or in end menner steted.							
200. Signature and the of certifier	× 11	29c. Licenso	e number	29	d. Date signe	d (Month, i	Day, Year)	
1 49/11	ualean	0.C.	M.E	2	AUGUST	18,1	999	
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	MIALEK		Street,	Baltimo	re, Maj	cylan	d 21201	
31. Defe filed (Month, Dey, Year)	32. Registrar's Signeture							
1440 - 0	999 Deneva	b. Spar	Ks					
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Registrar

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

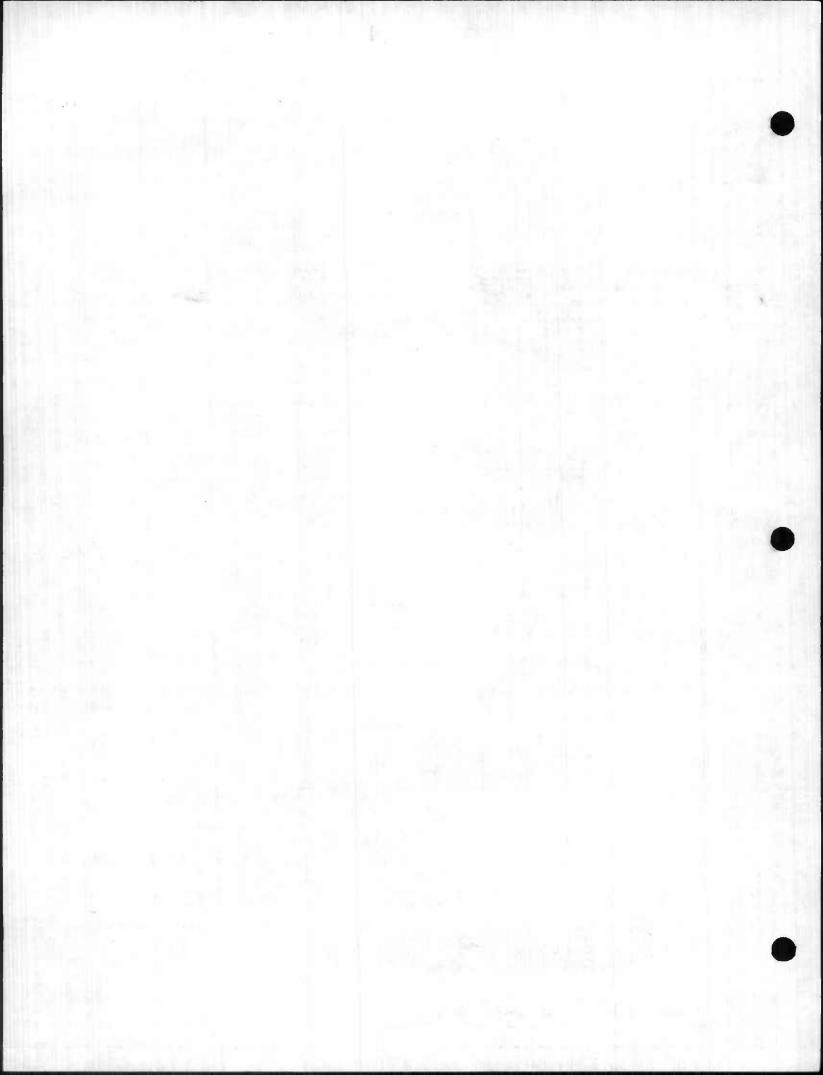


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State of Maryland / Department of Health and Mental Hygiene

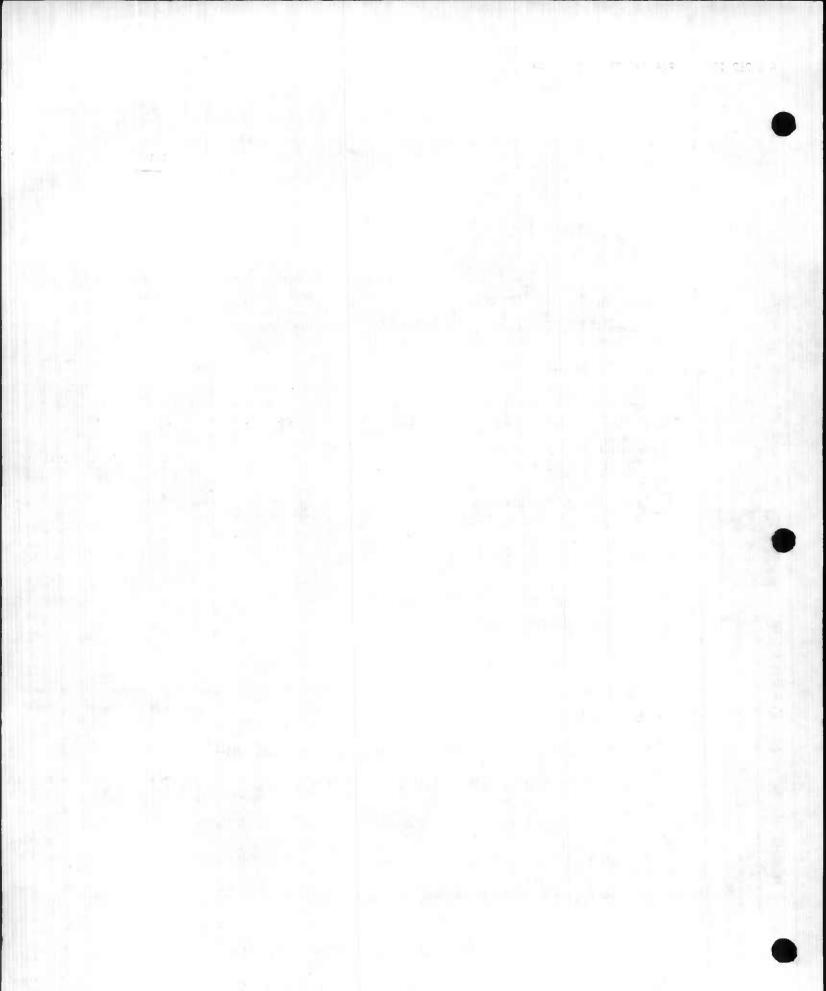
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 24, 1999 **Physician** WILLIAM WEISS 3:12 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE N/A Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1♥M 2□F Hours 88 Yrs. 145-22-0012 Director MAR. 9, 1911 ND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County N/A 1 X Yes 2 □ No MD Director BALTIMORE 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be r 304 KERNEWAY 21212 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? COAST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affined Polices 1 X Yes 2 No If Yes, Give GUARD filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 PROPRIETOR REAL ESTATE Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental MORRIS WEISS TEITLEBAUM GUSSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a iff Nem 27 is or other tra RUTH WEISS / WIFE 304 KERNEWAY - BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or 8/26/99 CHIZUK AMUNO ARLINGTON BALTIMORE, MD 21. Signature of Funeral Service Liberase 22. Name end Address of Facility SOL LEVINSON & BROS., INC. euri 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, show for healt failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Houte MyocARDIAL TNFORCTION
Due to (or as a consequence of): disease or condition resulting in death) Examiner CARDIO VASCULAR NISCASE Examiner ARTERIOSCLEROTIC hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): ce Renal 1

Due to (or as a consequence of): FAILURE Box 68760. Physician/Medical that initieted events resulting in death) Last CARDIO MY OPATHY 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yea 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? has page 2 1 Yes 2 DNo 1 DYes 2 No certificate of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No this funeral 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical completely (Check only one) 25 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Remelberrel H.D. 08297 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUG 2 6 1999 32. Registrar's Signature State Registrar Sparker



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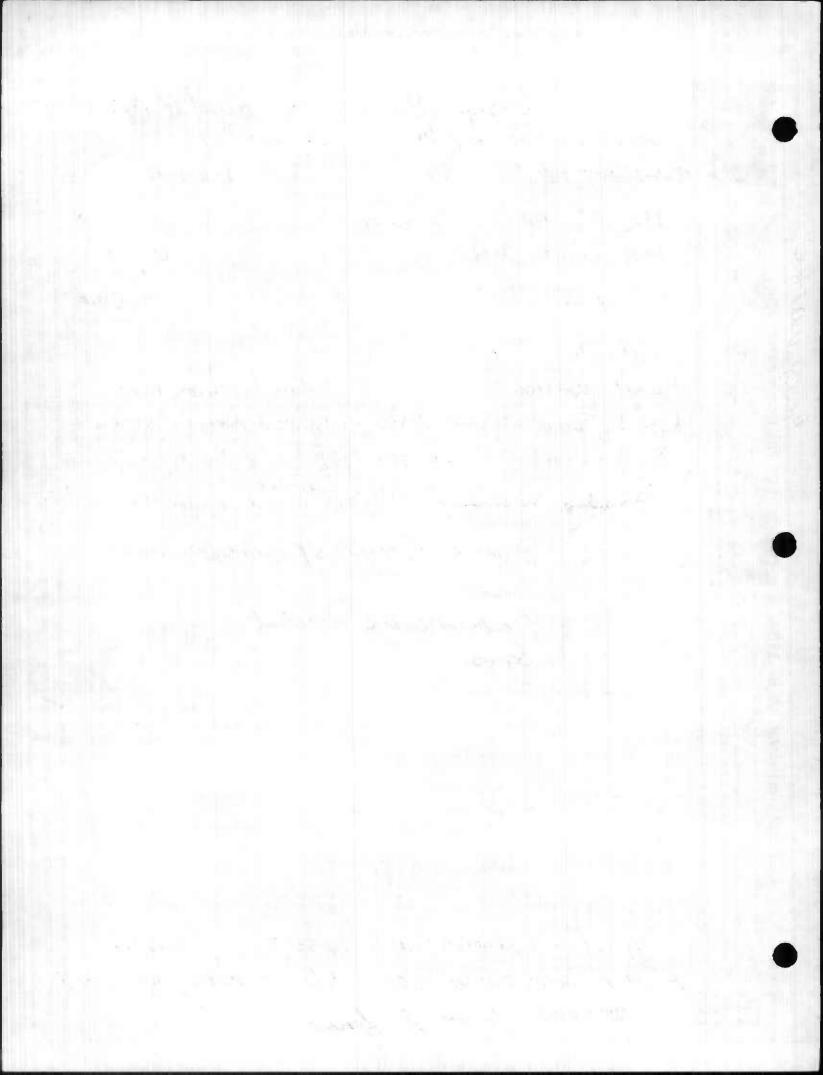
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uneral irector	5. Social Security Number 471–14–2656	7. Age (In yrs. las 79	Yrs. Month		Hours N	lin (Month Da	th Year) 1919 28, 199	9. Birthplace (St. Country) Minr	ate or Foraig lesota			
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be notified Director	10e. Street and Number	CIMOTE			Zip Code		T	10g. Citizen of V	What Country?			
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Muny .	4 Donation 5 Other		Assı	imption C		ery ess of Facility	8/26/99	St. CI	oud, Min	nesot		
op m	21. Signature o Funeral Servi	Tuneral	Home, In	c.								
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Examiner	Immediate Cause (Fine) disease or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of):											
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 155 **Physician** Milton ust reorge /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number Examiner Jakyland General 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** la 223-52-807 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits NA 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Sheraton Manufacture Elamentary/Secondary (0-12) Collega (1-4or 5+) Hygiene. Sofa Maker Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be 2 should be financial by Gladys Kobert 0 Walton Langhorn 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/209 19a, Informant's Name/Relationship (Type, Print) Sister Baltimore, 4800 Avenue Howwood laulor Saltimore. 20b. Place of Disposition (Natcemetery, crematory or 20c. Location - City or Town, State 20a. Method of Disposition Pages ment of P Burial 2 Cremetion 3 Removel from State eysuille 21. Signatura of Funarai Service Licensea 22. Name and Address of Facility larch F. H. West 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. 12al40 Hd 2/215 Avenue Physician etoacidosis & Marked Dehydration /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner attending physician and for use es the buriel-trensit Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last 4ccident Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 0 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical example? Be 26. Piace of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Ph n 24 hours efter death. 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifiar (Check only one) 1 Decrifying Physician: To the best of my knowledga, daath occurrad at tha time, data and place, and due to tha causa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number natura Ll. Macom 30. Name end address of person who completed cause of death (item 23a) (Type, Print) hin St. Balto, md. 21217 Naeem, M.D. 40 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

AUG 2 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ound aa 999 10:05 Am. Tugust 21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number Examiner Bat, more wenue enhi If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10 M 200 F 14-14-2029 9 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No NA Director 0 Hamore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ma 23a or 502 Was Decedent Ever in U.S. Armed Forces? enni Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 Black 1□ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygland Important: if Itam 27 is marked other the any injury or other traumatic avant, ans orker Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 51 1/2 Jenit er P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Kenhill Balfmore, My 2 20c. Location - City or Town, State Campbell Avenue aughter 02 20b. Place of Disposition (Name of Date Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cem athedral Ma 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Ba Ha, Md lad 21215 nue Ware 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 445 Examiner Examiner Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burla Box 68760, arguomo Physician/Medical Due to (or as a consequence of): for usa signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ρ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Illed in by 4 Homicide ò To the Funeral Di completely filled in Hospital edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. mination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) \$ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D25391 8-25-99 21

State Registrar

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31. Date filed (Month, Day, Year)

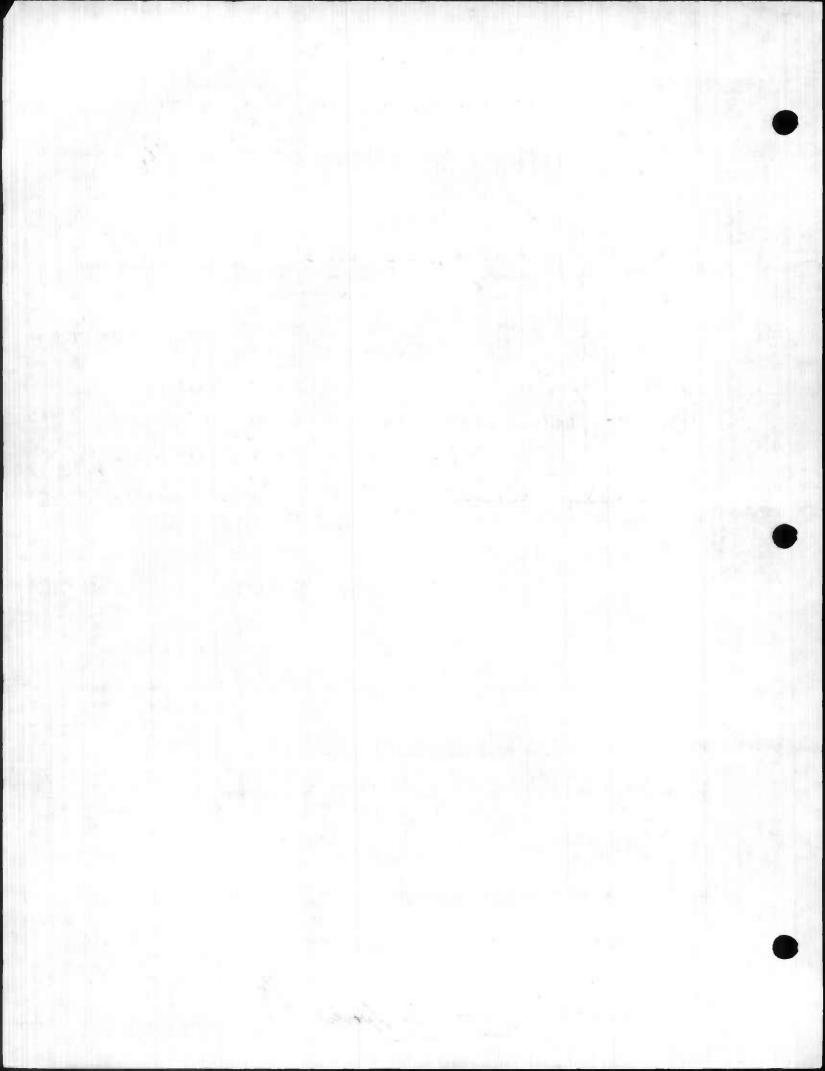
30. Name and address of person who completed cause of death (Item 23a) (Type Print)

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32. Registrar's Signatura G. Aparks

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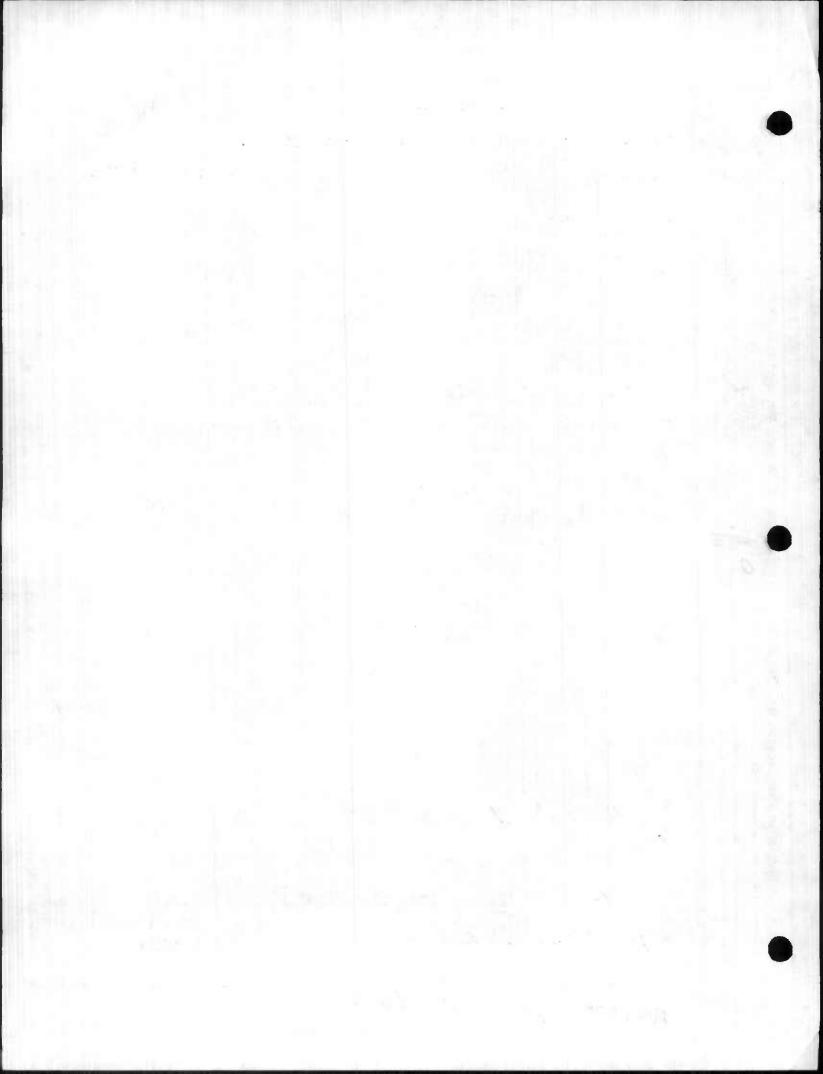


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Month Year **Physician** CHARLOTTE AMEILA BENDER ABELL AUGUST 8 1999 2:15pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System # Under 1 Year Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours t M 2 XF Director 01/31/1922 180-18-8363 Usual Residence of Dece Phila. with the Manyland words ! 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or flems 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9816 Martingham Circle Funeral 21663 USA 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 72 hours after 1 Never Married 2 Merried
3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yas, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any Injury or other traumatic avent, the Medicons. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles H. Bender Henrietta Schwehm 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9816 Martingham Circle, St. Michaels, MD 21663 Ernest G. Abell (Husband) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Hillside Cemetery 8/13/99 Roslyn, PA 21. Signatura of Funeral Service Lice 22. Neme end Address of Facility Beeson Memorial Services 315 2053 Pulaski Highway, Newark, DE 19702 iter the mode of dying, such as cardiec or respiratory errest, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final Left Ventricular Rupture diseese or condition resulting in deeth) 1 hr. Examiner Due to (or as e consequence of): Post-infarct Ventricular Septal Defect 24 hrs. the burial-transit and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): certificate be exec physician P.O. Box 68760 Myocardial Infarction 48 hrs. Physician/Medical Due to (or as a consequence of): **USe as** attending I for use as been signed by the s should be detached Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? has 2 No certificata 1 ☐ Yas 2 ☐ No Attanding Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 1 A Neturel 2 Accident 28b. Time of 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending Investigation i or Attandin after daath. | Director: Aft 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

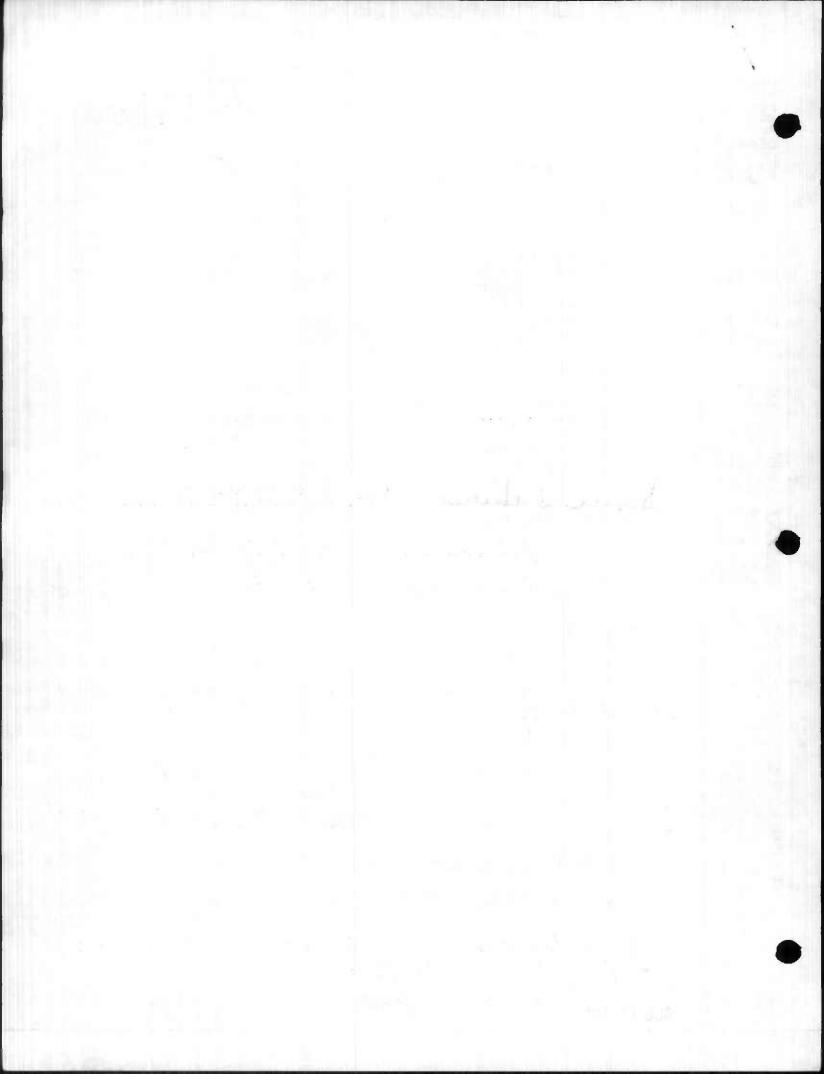
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESIDENT 46536 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) 20 KUCH WEHBERG. MD. 22 5. Greene Str Baltimore MD 21201 Umms 31. Date filed (Month, Day, Year) 32. Registrer's Signature State AUG 1 1 1999 Registrar

DHMH 16 Ray 6/95



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on o	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Mannar of Death	ing tigation	28a. Date of		28b.]	Firma of njury		8c. Inju			how Injury occu		11/2012	
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Sulcide 6 ☐ Could	d not be mined	28a. Place o	of Injury - At I g, atc. (Spec	home, fa	rm, stra	at, factor	, office		28f. Location (City or To		ber or Rura	al Route Number,	-
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical C	29a. Certifier (Check only one) 1 Certify Medica	ing Phys I Exami	sician: To tha b nar: On tha bas and mann	is of axamin	owladga letion and	, daath d/or inve	occurred estigetion	at the I	ime, data and place opinion, death occu	e, and dua to tha urred et the time,	cause(s) end n data and place	enner es si , and dua to	leted. tha cause(s)	
	vithin o th	Me	29b. Signature and tilla of certifi	ar /					29	. Lican	sa number		29d. Deta sign	ed (Month,	Day, Year)	
	->-0		N Va	No	n M	D				714	1314		fugk st	7 10	999	
			30. Nama and addrass of person	n who ~	ompleted cause	of death (Ita	m 23e/	Type P	Print)	7 / 1	,,,,		1 mg KS	/)//	, , ,	
			HI-WKGS	/	0	n ion	7/	13pg, P	Fal	1	elkton.	170	•			
	Sta	te	31. Data filed (Month, Day, Yea	r)	-/	gistrar's Sig	1/	1	-	1 6	1/ 1/					
	Registr		AUG 1 2 1999	/	Depur	P	. /	apo	w							



WRC 99-4568-019 CAROLYN M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 26807

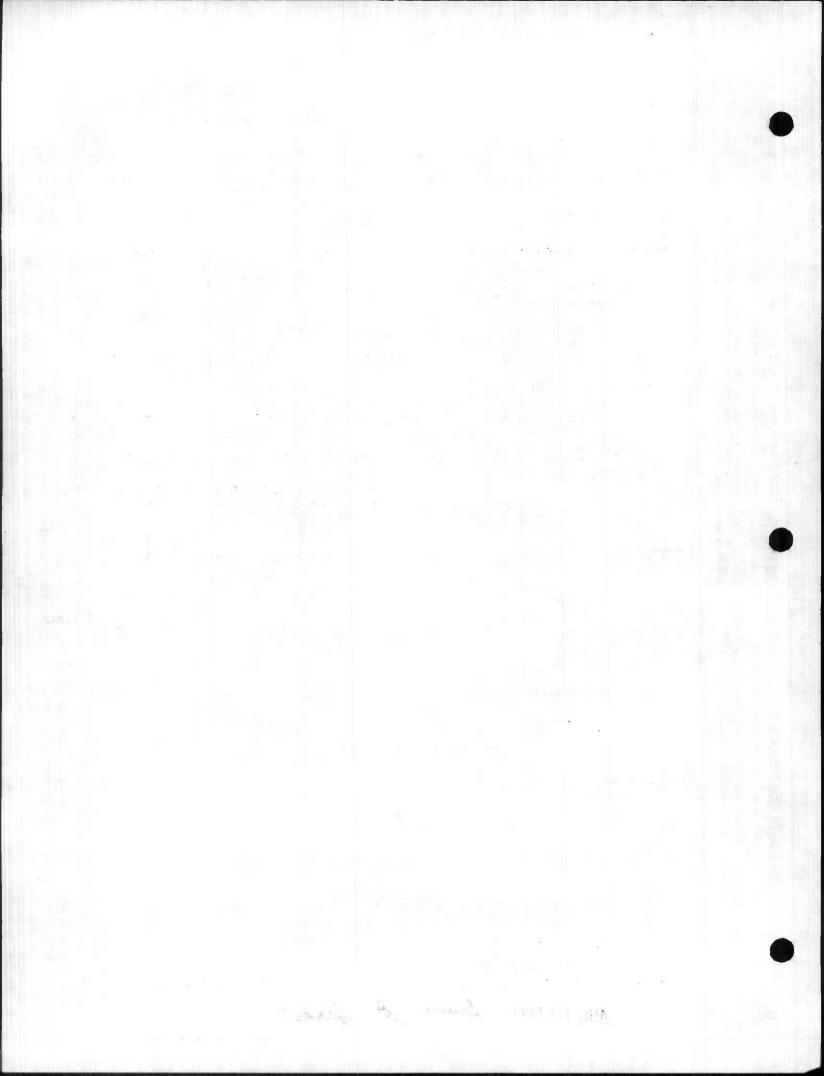
KE			Certificate o	f Death	B	eg. No.		
	1. Decedent's Nama (First, Middle, Las	()			2. Dete of Deat	h	3. Time of D	eath
Physician	Carolyn	Meekins	Blak	0	AUGUST	04°, 199	9 ^{ser} 3:00	AM.
/Medical Examiner	4a Facility Neme (If not institution, give		DIGA	4b. City, Town, or L	ocation of Death	4c. County		
LAditilici	DORCHESTER GENER	AL HOSPITAL		CAMBRIDG	E.	Dar	chester	
uneral	5. Social Security Number 6. Se		last birthday) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Country)	Foreign
rector	219-70-8315 1	38 38 38 38 38	Yrs. Months Dey	ys Hours Min.	08 - 15		New Jers	
	Usual Residence of Decedent				1-0-10		1000 0013	7
3 .	10a. Stete 10b. County	10c. Cit	ty, Town or Location				10d. Inside City	
ner must be notified at uneral Director	maryland Dorch	ester C	ambridge				1 ☐ Yes 2	2 III MG
Directo	10e. Street and Number		10f. Zip Code	•	1	0g. Citizen of W	fhat Country?	
4 IS	2606 Cambrio	loo Reltway	APL#6 2	1612		US	4	
Funeral	11. Meritel Status	12. Wes Decedent Ever in U Armed Forces?	S. 13. Was Decedent of	Hispanic Origin? (Suben, Mexican, Puert	pecify Yes or No-		- Amarican Indian, k, White, atc.	
	1 Never Married 2 Merried	1 ☐ Yes 2 ☐ No If Yes, Give	1 □ Yes 2 1 1 1	,	5 1 Hours, 4(0.)			
1 by	3 Widowed 4 Divorced	Year or Detes:	10 103 2121	о орвану.	4.00	Specify	Black	
Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usuel Occ	na during most of wor.	kina	16b. Kind of Bu	siness/Industry	
d'	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	ired)		0 1	. 01	1.
Co			Line W	orker		Toul	try Plan	+
Be	17. Father's Neme (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, M	Meiden Sumam	9)	
2	Louis		Webster	Gera			Meek	ins
	19e. Informent's Name/Reletionship (7	ype, Print)	19b. Meiling Address (Stre	01	-			
	Geraldine M.	zekins (mother	1503 Gard	ens Ct. F	ederals	bury h	nd 21632 City or Town, Stete	
	20e. Mathod of Disposition 1 D Burial 2 Cremetion 3 D		Plece of Disposition (Name of semetery, cremetory or other p	olece)	Dete	20c. Location -	City or Town, Stete	
	4 Donation 5 Other (Specify		ethel Ceme	tery	8/10/99 (Cambri	dee Mary le	and
á	21. Signature of Funeral Service Licens		22 Name and Add	trass of Facility	/ /	Lame	9.	
8	May D. O	Znivell		mith Fu 687 EAS		Tome	1 21621	
	23a. Part1 Enter the disease, or comp	idations that caused the deat	h. Do not enter the mode of d	lying, such es cardied	or respiretory erro	est,	Approximete	
an	shack or heart failure. List only o	na cause on eech line.					Onset and De	een
al	Immediate Cause (Finel disease or condition	41	1:01. 51.	1	1-			
er	resulting in deeth)	a. Pue to (c	or as a consequence of):	b wour	1015			
De		(
Examiner	Sequentially list conditions.	b Due to (c	or es a consequence of):					
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying							
edical	Cause (Disease or Injury thet initiated events rasulting in death) Last	c Due to (o	r as a consequance of):					
Wed	rasuling in dealin) Last							
		d					1	
Physician/	Part II. Other eignificant conditions co	ntributing to death but not res	ulting in the underlying cause	given in Pert I.	23b. Did to	bacco uee cor	tribute to the cause of	death?
th's					1 🗆 Y	e 2⊠No	3 Probably 4 U	nknown
Completed by					24a. Was a perform	n autopsy	24b. Ware autopsy fin available prior to	dings
Set					panon	ilea r	completion of ca of death?	usa
E C					1 PT Y	s 2 No	1⊉Yes 2□N	lo
	25. Wes case referred to medical			26 Pines of Dec	th (Check only on		12(160 201	
o Be	examiner?	Hospitel: 1 ☐ Inpatient 20	ER/Outpatient 3 DOA	Whor:	ome 5 Reside		or (Specify)	
-	27. Menner of Death	28a. Date of Injury	28b. Time of linjury 28c. In		28d. Describe ho			
tlor	1 □Neturel 5 □ Pending 2 □ Accident invastigetion	(Month, Day Year)	_ M 1	Vork? ☐ Yes 2,201 No	Sub'er	1	1-16	/
fica	3 ☐ Suicida 6 ☐ Could not be	28e. Place of Injury - At he	O137 m	×8	28f. Location (St	reet end Numb	S Stabbe er or Rurel Route Numb 2 Moores A	er.
Certification:	4 Homicide detarmined	building, etc. (Specif	y)		City or Town	1, Stele) 602	A Moores A	Jenu
	29e. Certifier 1□ Certifying Phy	Hous	wledge, deeth occurred et the	time dete end plece			Manyland	7
edical			tion and/or investigation, in m					
M	29b. Signeture end title of certifier		29c. Lice	ensa number	2	9d. Date signed	(Month, Dey, Year)	
	11 11	1 111 -		O.C.M.E.			5, 1999	
	Mysv	1 Via	CLIMD					
	30. Neme and eddress of person who c			Dollar		3 010	201	
	Stephen S. R		11 Penn Street	, Baltimoi	e, Mary	Lana 212	ZOT	
State	31. Data filed (Month, Day, Year)	32. Registrer's Signe	eture					

Registrar

AUG 9 1999 > Beneva

State of Maryland / Department of Health and Mental Hygiene 99 26808

		Certificate of	Death	Reg. No.						
	Decedent's Name (First, Middle, Last)			of Death	3. Time of Death					
Physician	GERTRUDE NIEMI BOESCH		Mor A110		Year 1999 0118					
/Medical	4e Fecility Name (If not institution, give street end number)		4b. City, Town, or Location of							
Examiner	The Memorial Hospital		Easton	Talbo	h					
	5. Social Security Number 6. Sex 7. Age (In yrs. le	ast hirthday) If Under 1 Year								
Funeral Director	380-16-0202 1□ M 2ĬXF 76	Yrs. Months Days		of Birth nth, Day, Year)	Birthplace (Stata or Foreig Country) TOUT CAN					
Director	Usual Residence of Decedent		ψAN.	10,1923	MICHIGAN					
Bu Bu		, Town or Location			10d. Inside City Limits					
tah leda	MD TALBOT	ST. MICHAELS			1 ☐ Yes 2 🔯 N					
vith the Ma t or 2ther's be notified Director	10a. Street and Number	10f. Zip Code		10g. Citizen of W	nat Country?					
	24345 WIDGEON PLACE #29		1663							
r there 23a siner must 3				USA	- American Indian,					
Date of	Armed Forces?	If Yes, specify Cut	Hispanic Origin? (Specify Ye pan, Mexican, Puerto Rican, e	tc.) Black	, White, etc.					
by F	1 Never Merried 2 Merried 1 Yes 2 No If Yas, Give Yeer or Dates:	1 ☐ Yes 2 No	Specify:	Specify:	WHITE					
		10: Deceded the Head Con	nation	t6b. Kind of Bus	in and finductor					
ygiene. ser than *natur t, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	100. Kind of bus	wiessymoustry					
Page C	Elementary/Secondery (0-12) College (1-4or 5+)		,u)							
	12 17. Father's Neme (First, Middle, Last)	TEACHER	18. Mother's Name (First,	EDUCA'						
Be ever	CHARLES NIEMI									
Months To			HILDA KA		No. 7: O. d. 1					
bra of the state o	19a. Informent's Neme/Reletionship (Type, Print) DAVID S. BOESCH/ HUSBAND		ing Address (Street and Number or Rural Route Number, City or Town, State, 2 15 WIDGEON PLACE #29, ST. MICHAELS, M							
toalth in 27 har t										
1 and 1	1 Rurial 2VVC comption 3 DRomoval from State C8	ace of Disposition (Name of metery, cremetory or other plant of the p			City or Town, State					
iny and	4 Donation 5 Other (Specify)	SAPEAKE CREMAT	ION CTR. 8-12	-99 STEVENS	VILLE, MD					
the state of	21. Sign aroun of Funerel Service Licensee	22. Name and Addr								
SEEB	VM 5 11. KI	FELLOWS,	S, HELFENBEIN & NEWNAM FUNERAL HOME, P. HARRISON ST., EASTON, MD 21601							
	23a. Part1. Enter the disease, or complications that caused the death.				Approximate					
	shock, or heert feilure. List only one cause on aech lina.	. Do not onto the mode of dy			Interval Between Onset and Death					
hysician Medical	Immediate Cause (Final	~.								
xaminer	Immediate Cause (Final disease or condition resulting in deeth)	Diratory Dis	stress sy	ndrome	3 WEEKS					
	Immediate Cause (Final disease or condition resulting in deeth) a. Adult Ress Due to (or Sequentially list conditions, Dua to (or Sequentially list conditions,	es a consequence of):								
in and intransit	Sepsis	Syndro	ne		3 WEEKS					
sician and burial-transit	Sequentially list conditions,	as a consequence of):								
dian m	Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury	in			3 WEEKS					
physician s the burie	that initiated events rasulting in deeth) Last	es e consequence of):								
as X										
for use	d				1					
igned by the attend be detached for us by Physiclan/	Pert II. Other significant conditions contributing to death but not result	Iting in the underlying cause g	iven in Part I. 23	b. Did tobacco use conf	ribute to the cause of deati					
by the tached		1 .1 1 -	2. 1.	1 □ W 2 □ No	3 Probably 4 Unkno					
be de de dy d	Lung Cancer - ma	240STOUTIC	to brain							
een signed by the attending physician a hould be detached for use as tha bunal- sted by Physician/Medical Ex	Lung Cancer - ma Cerebrovascular aci	10	24	a. Was an autopsy	24b. Were autopsy findings					
ahould integrated	Cerebrorascular aci	cidens		performed?	available prior to completion of cause of death?					
has ye 2	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
cate ha	lende fatture			1 Yes 2 ANO	1 Yes 2 Ne					
s certificate director, pag To Be Co	25. Wes case referred to medical exeminer?		26. Place of Deeth (Chec	k only one)						
E E	1 Yes 2 Hospitel: 1 Impatient 2 E	Ervoutpatient 3LI DOA		Residence 6 Othe						
h. After this certific funaral director, tion: To Be	27. Manner of Death 1 Naturai 5 Pending (Month, Day Year)	28b. Time of thingury 28c. Injury Wo		scribe how injury occurre	d					
	2 Accident investigation	M 10	Yes 2□No							
within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of tnjury - At hor building, etc. (Specify)	ma, farm, street, factory, office	28f. Loc Cin	ation (Street and Number or Town, State)	r or Rural Route Number,					
within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	Samuel, Copouly)									
hour y fills	29e. Certifier 1 Certifying Physician: To the best of my know									
n 24 hou ve Funer pletely fil edical	(Check only one) 2 Medical Examiner: On the basis of examination and mannar stated.	on and/or investigation, in my	opinion, death occurred at th	e time, date and place, a	nd due to the cause(s)					
om om	29b. Signature and title of certifier	29c. Licen	se number	29d. Dete signed	(Month, Day, Year)					
>-0	the mo	De	PUT 49	8/11	99					
	, , , , , , , , , , , , , , , , , , , ,	0	(/ ()	0 [11	1 1					
	30. Nama end eddress of person who completed cause of death (Item									
	PETER L. WHITESELL, M.D., 508		JE, EASTON, MI	21601						
State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signati	ure 4 /								
Registrar	AUG 1 3 1999	p. pp	res							



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0605 August BULGER JAMES VINCENT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner CHESTERTOWN KENT KENT & QUEEN ANNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) June 1 19 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 18 M 2□ F Days Hours Min 190-16-8026 80 Yrs. 1919 Pennsylvania **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at page. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No MD Kent Millington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Sassafras St. 21651 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black White etc 1 ☐ Never Married 2 ☐ Married 1 Ves 2 No Specify White Specify: 42/45 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Pennsylvania College (1-4or 5+) Elementary/Secondary (0-12) Military College 10 Welder 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) John L. Bulger Mary K. MacNeil 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Blackiston (daughter) 161 Sassafras St. Millington, MD. 21651 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Chester Rural Cem. 8/18/99 Upland, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD.

118 West cross St. Galena, MD. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final minute Carlac disease or condition resulting In death) Examiner Due to (or es e consequence of) Physician/Medical Examiner and I-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ue to (or as a consequence of): physician ar s the bunal-t Division of Vital Records, P.O. Box 68760, tadrycardia SS signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No ASCAD, HTN, BPH, hyponatromia, 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Was an autopsy performed? methicillih resistant styph. aureus cartificata has irector, paga 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 Certification: To this After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / complately filled in by the f 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifit 29c. License number 0

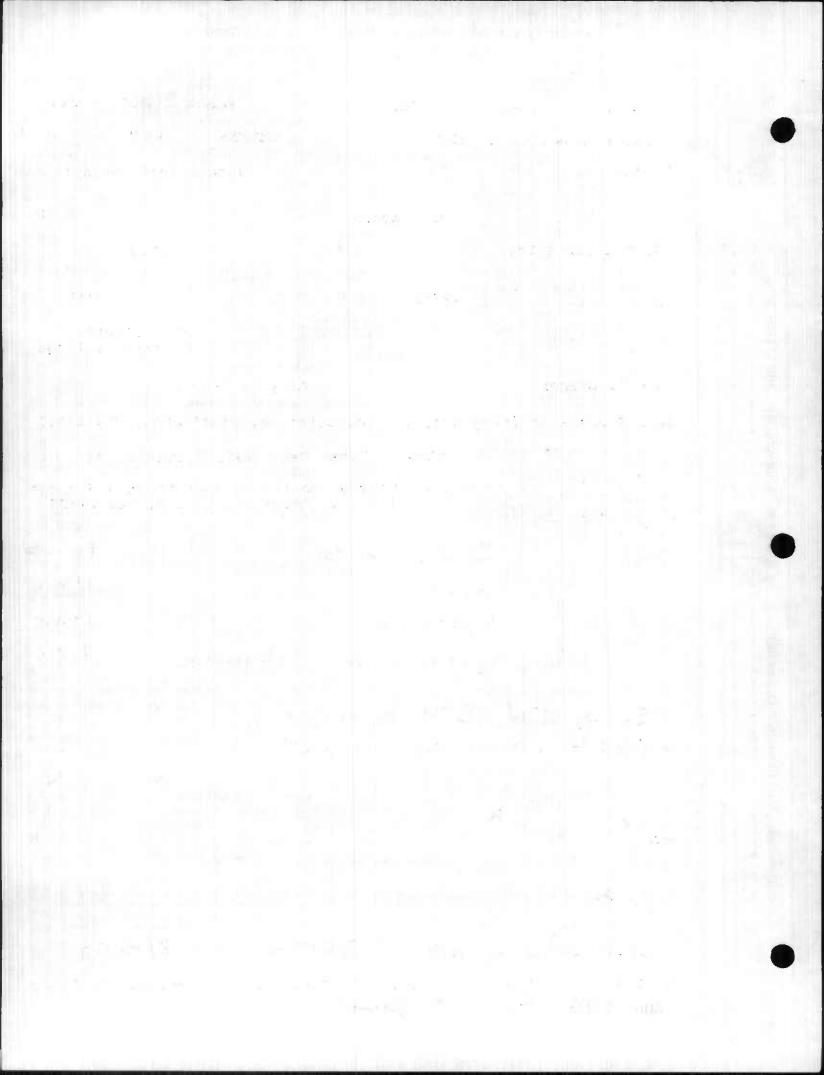
HIVA

State Registrar

Frederick W.

Delboy MD 6602 Church Hill Rd. Chestertown, MD. 21620 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Q 2 6 8

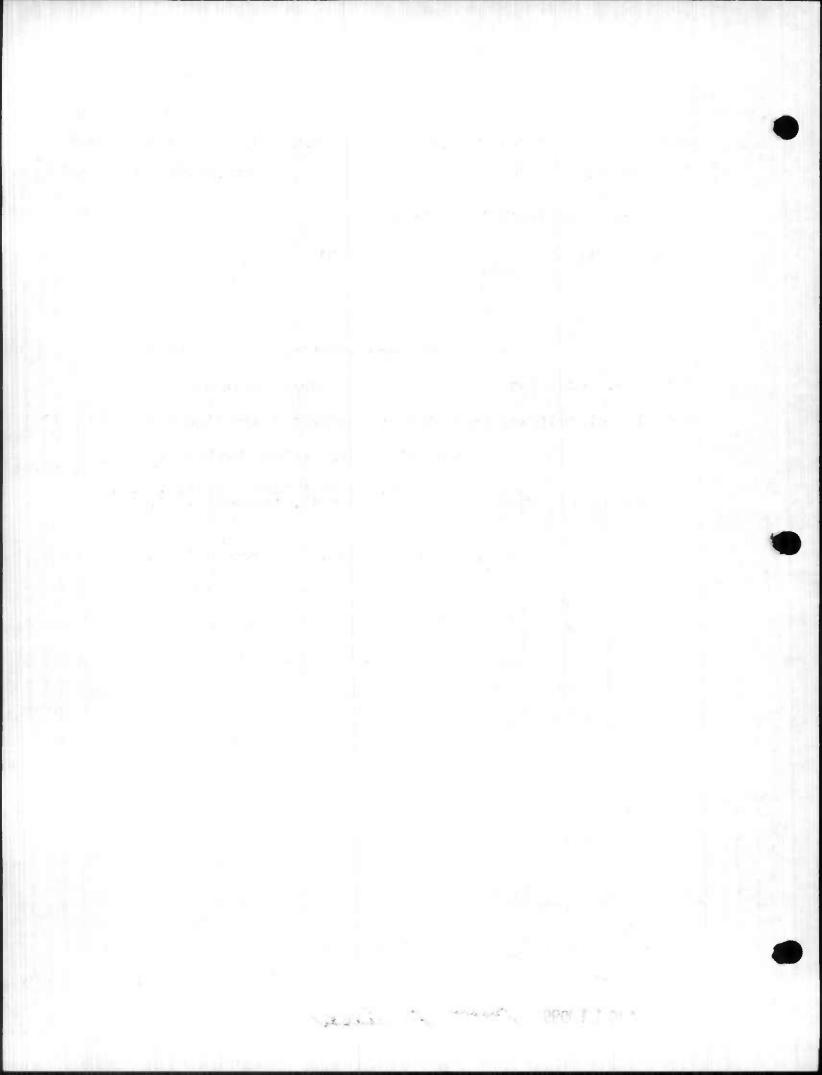
_	Decedent's Neme (First, Middle, Last)	Ce	rtificate of	Death	2. Date of Death	g. No.	3. Time of Death			
Physician						Month	Dey	Year			
/Medical	Mary Elizabeth 4a Facility Name (If not institution, give	Brady			41 Ob T-	August 9	1999	12:15 PM			
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death			
4	Anne Arundel Me				Annapol			Arundel			
Funeral	5. Social Security Number 6. Se.		In yrs. last birthday	Months Days			Year)	Birthplaca (Stete or Foreign Country)			
Director	577-26-6279 Usual Residence of Decedent	M 2 F 84	Yrs.			\$ept.11,1914 Tennessee					
a Bu	10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits			
Mar Hed	Maryland Anne Aru	ndel	Edgewater	r				1 ☐ Yes 2 ☐ No			
with the Maryle a or 28e-f show the notified at I Director	10e. Street and Number 804 Shore Drive			10f. Zip Code 21037		10	g. Citizen of W				
ther death w r lisms 23s siner must 1 Furneral I	11. Maritel Status	12. Was Decedent Ev	erin IIS 13	Was Decedent of	Hispanic Origin? (Specify Ves or No-	USA 14 Bace	- American Indien,			
ural, or hama al Examiner m of by Funer		Armed Forces?	61 11 0,3.	If Yes, specify Cut	oan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		k, White, etc.			
Exam by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		1□ Yes 2√ No	Specify:		Specify:	White			
ted fall	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation	t t	6b. Kind of Bu	siness/Industry			
t, the Medical.	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life.	b kind of work done DO NOT use retire	during most of word)	жылд					
the C	12	2	Clerk	<			County	Government			
	17. Father's Neme (First, Middle, Last)	2	OTCI		18. Mother's Na	me (First, Middle, M					
o Be	Joseph Cysh Hayes					th Agnes 1					
T BEE								0 7. 0			
1	19e. Informent's Neme/Retationship (Ty					lural Route Number.					
	Gail L. Johns / Da	aughter			ive, Edg	ewater, Ma	-				
8	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ F	amoust from State	20b. Plece of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Dete 2	Oc. Location -	City or Town, Steta			
10	4 □ Donation 5 □ Other (Specify)		Hillcrost	- Memoria	1 Garden	8-12-99	Annano	lis,Maryland			
하는 속	21. Signatura of Funeral Service License			2. Name and Addr		5 0 12 17	minapo	115 Mar Viana			
on and	· Wandlel.					neral Home	e				
	" Mony Cuun		20	973 Solom	ons Isla	nd Road, J	Edgewat	er, Maryland			
	23a. Part1. Enter the disease, or compleshock, or heart tellure. List only or	ications thei caused the	ne death. Do not en	nter the mode of dy	ing, such as cardia	c or respiretory arre	st,	Approximate Intervat Between			
ician			y c	-) /				Onset and Death			
lical	Immediate Cause (Final	SEY	2/20	MACK				24 have			
iner	disease or condition resulting in death)	01/2	112	10011				11000			
3 8		Revo	ue to (o) as a conse	iquenge of):				12 2 2			
Examiner		0. 100 10	(1)	CHETT	U			7 1 700VJ			
odical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	De	ue to (or as a conse	quence ot):							
- m	cause. Enter Underlying Cause (Disease or Injury	3	380								
edical	that initiated events resulting in death) Last	Du	e to (or as a conse	quence of):							
5		1						1			
5	Part II. Other algnificant conditions cor	ntributing to death but	not resulting in the	underlying cause of	iven in Part I	23h. Did tob	DECCO USE CON	tribute to the cause of death?			
Physician/M	which digital continues con	o domin but i	roodining in tille t					3 Probably 4 Unknown			
=						1 Ye	. 20,40	3 Probably 4 Onknown			
d by Physic						040 111-0	autocau	24b. Were autopsy tindings			
Completed						24a. Was an perform	ed?	evailable prior to completion of cause			
Comple								of death?			
E						1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No			
	25. Was case reterred to medical				ne Disease I D						
Be	axaminer?	lospitel:			ther	eth (Check only one					
To Be	TIL THES ZILING	1 LU/Inpatient		INT 3 DOA	4 U Nursing	Home 5 Resider					
d in by the funeral discrification: To	27. Menner of Death 1 □Natural 5 □ Pending	28e. Dete of Injury (Month, Day Y	(ear) 28b. Time (Wo		28d. Describe how	w injury occurr	90			
at a	2 Accident investigation			M 1	Yes 2□No						
completely filled in by the funeral	3 Suicide 6 Could not ba 4 Homlcide determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet end Numbe State)	er or Rural Route Number,			
etely filled in dical Cer											
edicai	29a. Certifier 1 Certifying Physical Check only one)		caminetion and/or in	th occurred at the to	ime, date and place opinion, death occ	e, and due to the car curred at the time, da	use(s) and ma te end placa, a	nner as stated. and due to the cause(s)			
Med M	29b. Signature and title of certifier	and manner stete	u.	29c, Licen	se number	29	d. Date signed	i (Month, Day, Year)			
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		men	110	1050	77)	/-	715	174/1777			
	30. Nama and address of person who co	empleted cause of dea	th (Item 23a) (Type	Print) /	1	2	1	0 13			
	Ira WEMI	Tein 6	00 1	410/11/	VHV	ITAY	200/1	7/10			
State	31. Date tiled (Month, Day, Year)	32. Registrar	Signeture	,	/)	1	1			
State				/							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LINDA Brownlee 8 1999 11:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

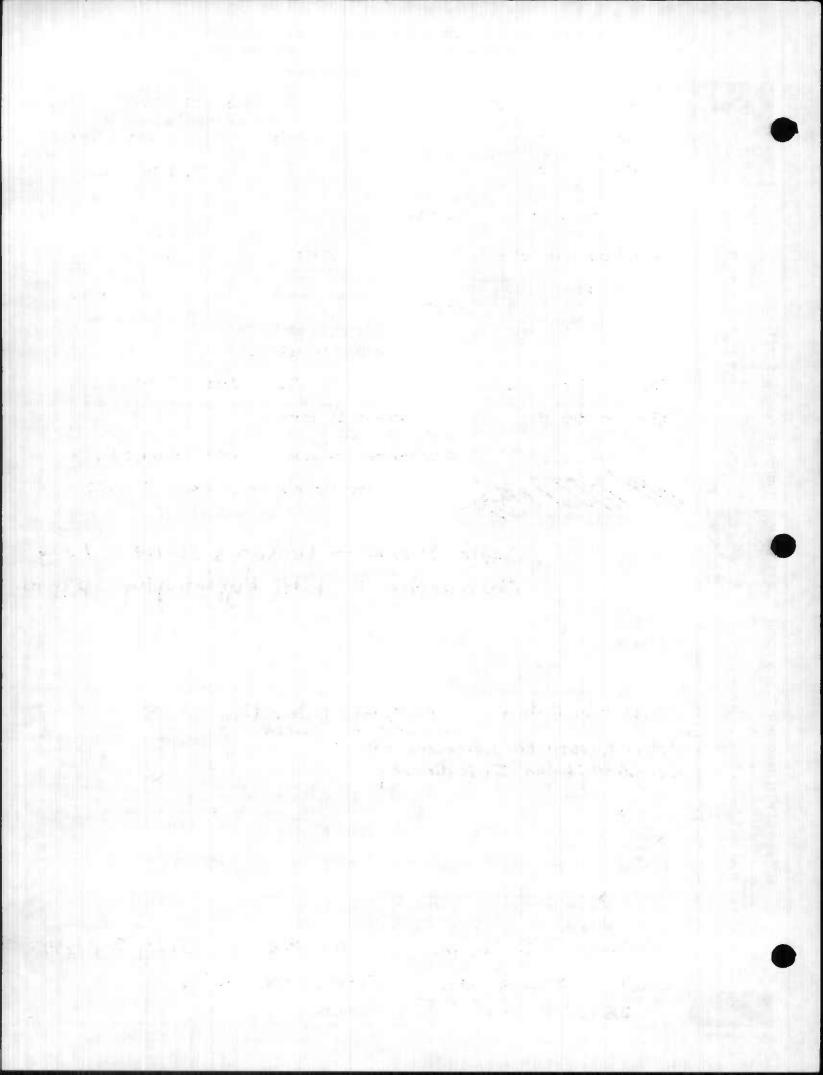
Jun. 12, 1951 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Days 1□ M 25 F 212-74-9287 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at 1X Yes 2□No Anne Arundel Annapolis Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 US 12 Bates Street Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event." Elementary/Secondery (0-12) College (1-4or 5+) Daycare Provider Homemaker 9th 0 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph H. Pergerson Sarah Smothers 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tershia Holland(Daughter) 7824 Woodside Terrace Glen Burnie, Md. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Annapolis Mem. Gardens 8-12-99 Annapolis, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Reese & Sons Mortuary, P.A. wm. 821 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** failure 2° Congestive heart /Medical Immediata Cause (Final disease or condition resulting in death) **Examiner** failure Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Bud Due to (or es a consequence of): small cell lung Cancer > 1 year P.O. Box 68760. Physician/Medical Wioni Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown rension Records, Q 24b. Were autopsy findings evellable prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 □ ER/Outpatient 3 □ DOA this funeral Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 To the Hospital o within 24 hours of To the Funeral Di completely filled is 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Internal Medicine H005284 30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Admiral Cochiane Drive AnnaplismD SWADY PETER 180 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 1 1999



State of Maryland / Department of Health and Mental Hygiene 99 268 12

						Ce	rtificate	e of	Death			Reg. No.				
- 61	Decedent's Name (First, Middle, Last)										2. Date of D	Davi	Year	3. Tima of Death		
Physiciar /Medica	_	0vi1	Lee	BOLLIN	VG						July	31, ^{bay} 199	1, 1999 12:			
Examine	_	464 Saral	-		imber)				4b. City, To Lothi		ocation of Daa		y of Death ne Ari	undel		
Funeral Director		5. Social Security Nu 218 03 48		Sex 1√2 M 2□ F	7. Aga (In yrs. la 80	ast birthday) Yrs.	If Under Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D May 2	th ay, Year) 4, 1919	9. Birthp Cour V	olaca (State or Foreign htry) A		
pue *	-	Usual Residence of D	Dacedent 10b. County		10c. City	, Town or Lo	ocation						1	Od. Inside City Limits		
h the Merylen r 28a-f show Inotified at		MD	Anne Arı	ındel		hian	,							1 Yas 2 No		
23s or 2	al Dir	10e. Street and Number 464 Sa:	_{ber} rah Anne	Drive			10f. Zip		711			10g. Citizen of What Country? USA				
urs.	by Fur	11. Marital Status 1 Never Marrie 3 Widowed 4		Armed F	2 No		Was Deced If Yes, spec	ify Cub	an, Mexicai	gin? (Sp n, Puerto	ecify Yas or N Rican, etc.)		ce - Amaric ick, White, fy: W			
C -	Completed	(Specif	15. Decedent's E y only highest gr	ducation ade com <i>pleted)</i>)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	al Occup rk done	etion during mos	t of work	ring	16b. Kind of E	lusiness/In	dustry		
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od 2 sh lith and lith and 27 is m traum		19a. informant's Nar Helen B	(Type, Print) Vife	ral Route Numi	ber, City or Town	o, State, Zip	o Code)									
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permit. Pa Departmer Important any Injury stice.		21. Signature of Furneral Service Licensee 22. Nama and Address of Facility Rausch Funeral Home, Owings, MD 20736														
TO THE OWNER.	ť	23a. Part1. Enter the	e disease, or con	nplications that	caused the deeth	. Do not en	ter the mod	e of dyli	ng, such es	cardiac	or respiratory	arrest,		Approximate		
Physician /Medicai		Immediate Cause (F	failure. List only			Shar	K -		Mcc	CON	08 15	source		Interval Between Onsat and Death		
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and -transit	xamir	Sequentially list conditions, if any leading to immediate b. Obstructive Prostant C Ryperfrophy Due to (or as a consequence of):												2 9 113		
certificate be executed ding physicien and use es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):													37-4		
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or Attending efter death. Director: After d in by the fune	ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	286. Plac	a of Injury - At ho ling, etc. (Specify	me, farm, st	raat, factory	, office			281. Location City or To	(Street and Num own, State)	ber or Rur	al Routa Number,		
To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral	27. Mannar of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar stated.									nanner as	stated. to the cause(s)					
ro the within romple	29b. Signature and title of cartifier 29c. License number									29d. Data sign	ed (Month	, Dey, Year)				
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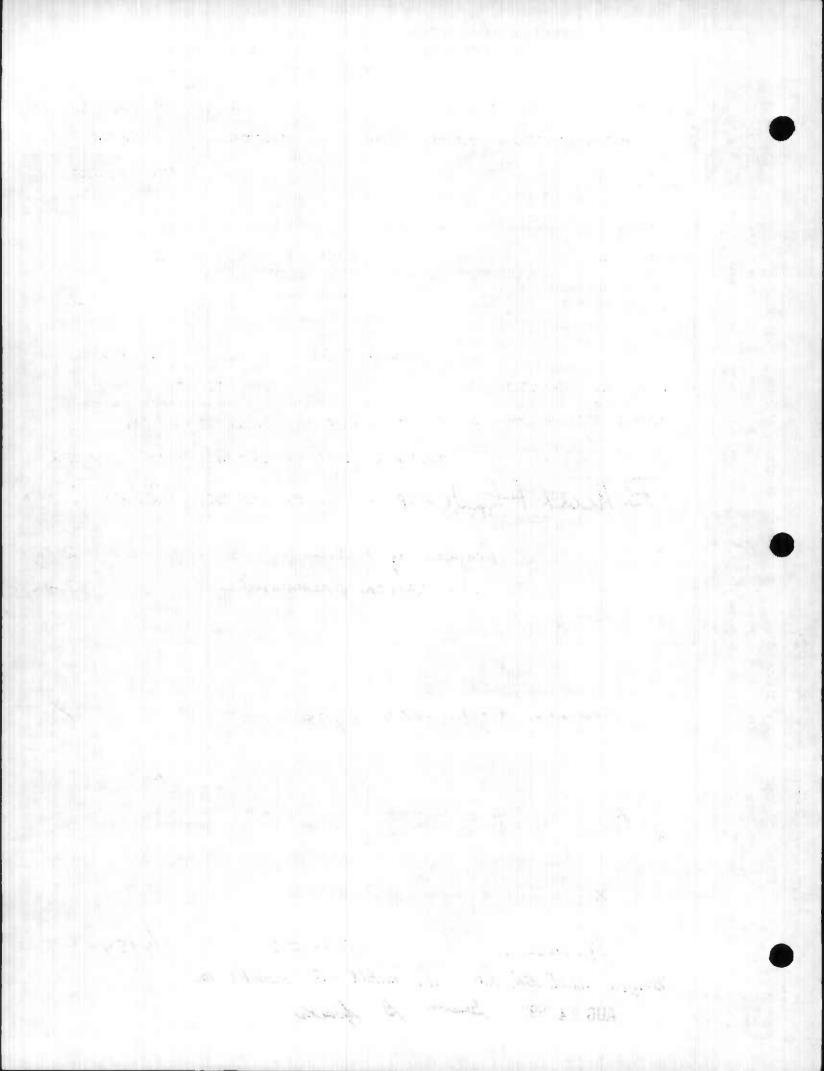
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1600 August 1999 FLIZABETH EMILY BRATTEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□ M 2Ĭ F Months 68 Director 226-36-7424 VIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo MARYLAND WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 928 S. PARK DR. 21804 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify g WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POULTRY GROWER OWN FARM 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of Peges 1 and 2 should be AARON CAMPBELL MAMIE HUNLEY J. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health and Important: If Hem 27 is m any Injury or other traum LORIE BRATTEN CORRON - DAUGHT. 928 S. PARK DR. SALISBURY, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Melhod of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State SPRINGHILL MEMORY GARDEN 8/6/99 HEBRON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility any Ir 705 E. MAIN ST. FSP BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Respiratory /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner SPIRATION attending physician and for use as the buriel-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that infliated events Dua to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 6 Alzeheimers peudis Completed by 24b. Were autopsy findings availeble prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 s 2/0 No 1 ☐ Yes 2 ☐ No 1 Yes this certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deet 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Director: After or Attending Naturei 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier edicai and mannar stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Huddleston, M.D. salisbuly, mo miltord 104 31. Date filed (Month, Day, Year) 32. Registrar's Signature **AUG 0 4** Registrar

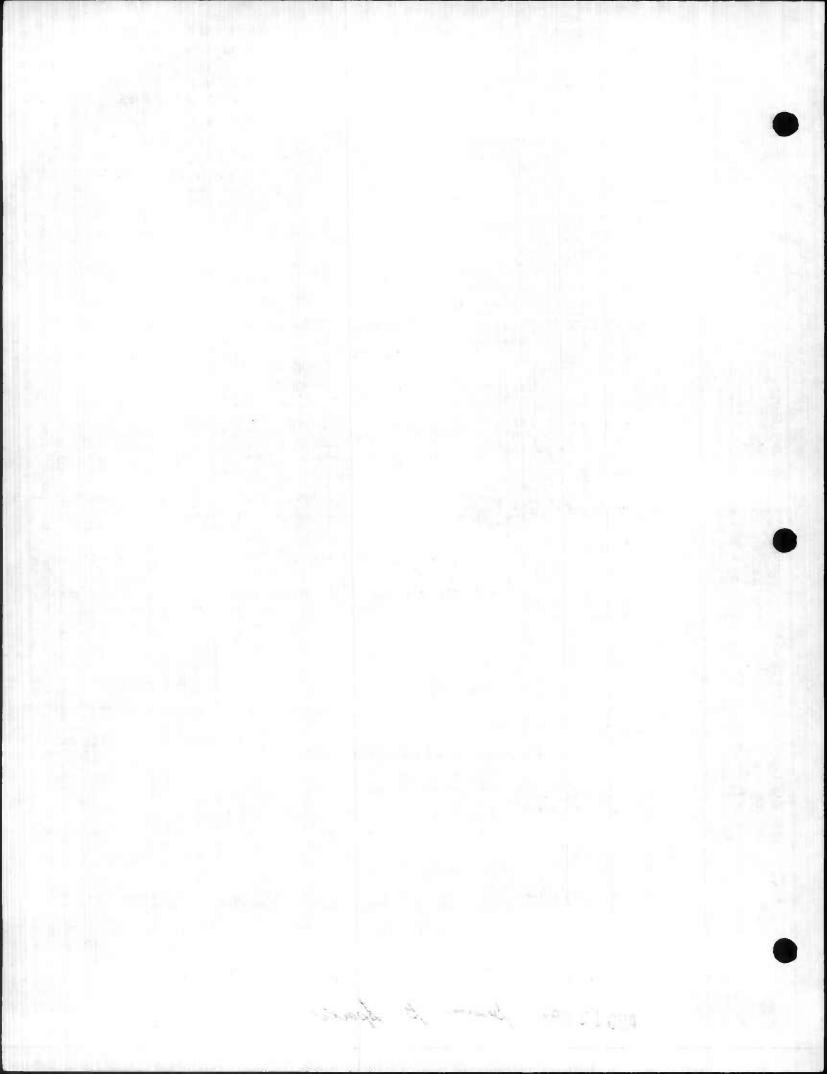
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Flizabeth Chatten



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n of Vital Records, P.O. Box 68760,	g Physician: The law requires that the death certificate be axecuted

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/Medica Examine Funeral	r	4e Facility Neme (If not institution BERLIN NURSING 5. Social Security Number		TLITATION 7. Age (In yrs. Is	st birthday)		-	RLIN	8. Dete of Bir (Month, Da	WOR	y of Death CESTE 9. Birth	place (Stete or Foreign
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ages 1 and 2 should ent of Health and Men till flem 27 is men'he y or other traumatic	4	19a. Informant's Neme/Relations BETTY DAVIS BRO 20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S	BST/WIFE	n Stete Ce	P.O.	BOX 241 sition (Name of netory or other ple	BISH	HOPVI	Date	ARYLAND 20c. Location	2181 - City or To	3
permit. P Departme Importan any injur ance.		21. Signature of Euflieral Service			22	. Neme end Addre	ss of Facili	ty				LAWARE 1997
- La	arymedicai Examiner	23a. Peril. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that imitated events resulting In death) Last	a. E7	Due to (or	es a conseques a conseques a conseques a conseques a conseques a consequence a consequ	Rer ruence of): Neuence of):			- ,	Inc		Approximate intervel Between Onset and Deeth Pervenue
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aw requir	Completed by Physician	010	e reb	no Vo	is ce	1560 n	Gea	les	24a. Was	an eutopsy omed?	of	Vere autopsy findings valiable prior to completion of cause death?
ysician: The l	200	25. Wes case referred to medica					26. Place	e of Deat	1 Check only		1	Yes 2 2 No
5 5 8	9	exeminer? 1 Yes 2½ No 27. Manner of Death 1 X Natural 5 Pendin	28a. Dat		PVOutpatien 28b. Time of Injury	t 3 DOA Oth				dence 6 00 how injury occu		fy)
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To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical		Examiner: On the	e best of my know basis of examination								
To Within		29b. Signature end title of pertifie		7		29c. Licens	2026			29d. Date sign		
JUA	a	30. Name end eddress of person Federcio G. A	who completed car rthes, M.	D., 46 T	eal Ci	rcle, Be	rlin,	MD	21811			
State Registra	9	31. Date filed (Month, Day, Year) AUG 12		Registrar's Signatu	10 B	Spark						



sician edical	Donald Wesley BIVENS, Jr.		of Death			3. Tima of Death
	-			Day 199		9:20 am
miner	4a Facility Nama (If not institution, give street and number) Anne Arundel Medical Center Annay	Town, or Location of	of Death 4c. County of Death Anne Arus			del
eral tor	5. Social Security Number 218 54 8394 6. Sex 7. Aga (In yrs. last birthdey) Months Days Hours	or 24 Hrs. 8. Date	of Birth th, Day, Y		9. Birthp Coun	lace (State or Foreitry) h., DC
T.	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. fnside City Limi
leted by Funeral Director	MD Prince George's Upper Marlboro					1 ☐ Yes 2 🛣 N
Je Je	10e. Street end Number 10f. Zip Code		10g	. Citizen of W	/hat Coun	itry?
al	15408 Marlboro Pike 20772			USA	1	
	11. Meritel Status 12. Was Decedent Evar in U,S. Armed Forcas? 12. Was Decedent of Hispanic C if Yas, specify Cuban, Mexic Yas or Detes: 13. Was Decedent of Hispanic C if Yas, specify Cuban, Mexic Yas or Detes:	an, Puerto Rican, el	or No- c.)		k, White,	an Indian, etc. white
mpleted	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usuat Occupation (Give kind of work done during me life. DO NOT use retired) warehouse manager	ne during most of working red)				
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	19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Num		Number, C			Code)
	Debora Fowler Kelly (cousin) 5959 Rose Court,	St. Leon	nard, MD 20685			
	20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Resurrection Cemetery	Date 8-7-9)	c. Location -		
	21. Signature of Euroral Sacrice Licensee 22. Neme end Address of Fac Rausch Funeral	Home, Ov	vings	, MD	2073	6
	Due to (or es a consequence of):	ceiele				Approximate Interval Between Onset and Death
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	4 Li Homicide bullding, etc. (Specify)	City	or Town, :	State)		
dica	29e. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date of the composition of the carmination end/or investigation, in my opinion, do and manner stated.					
M	29c. License numbe D 5 3 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) HUNG DAVIS Anne ARUNDEL Hea			1. Dete signed	.4	
	30. Name and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print)			14	MIC	MA 2140

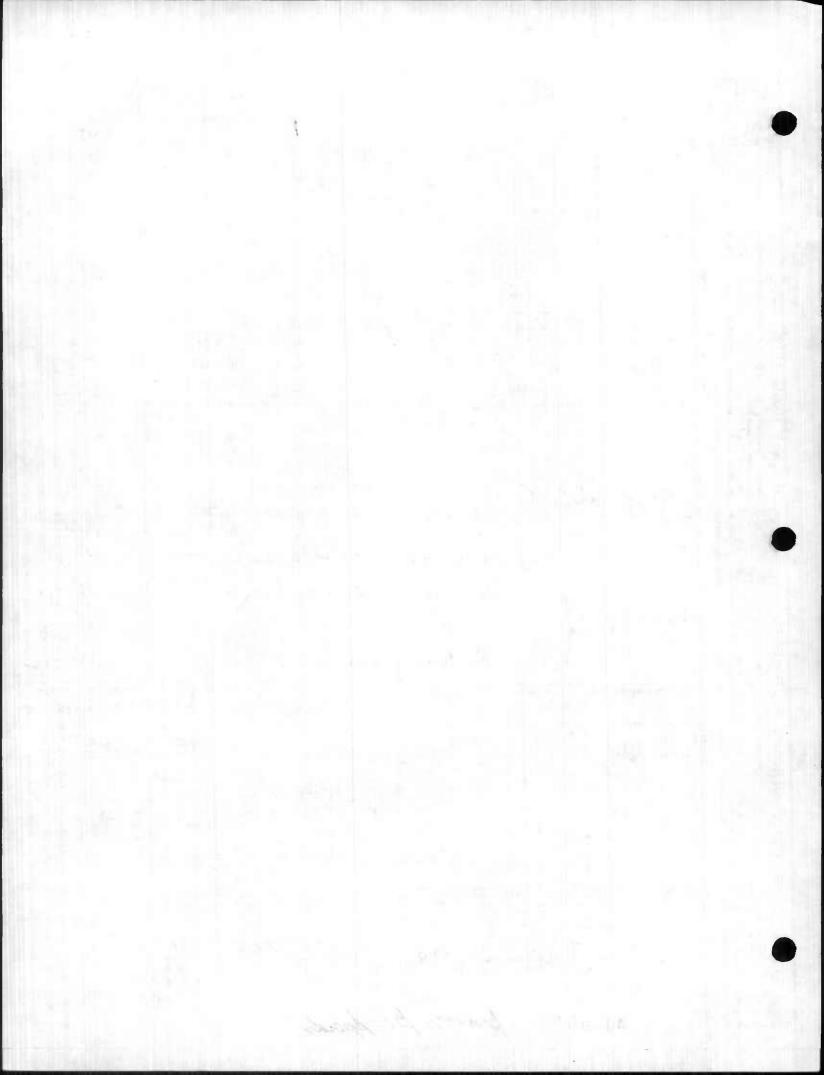
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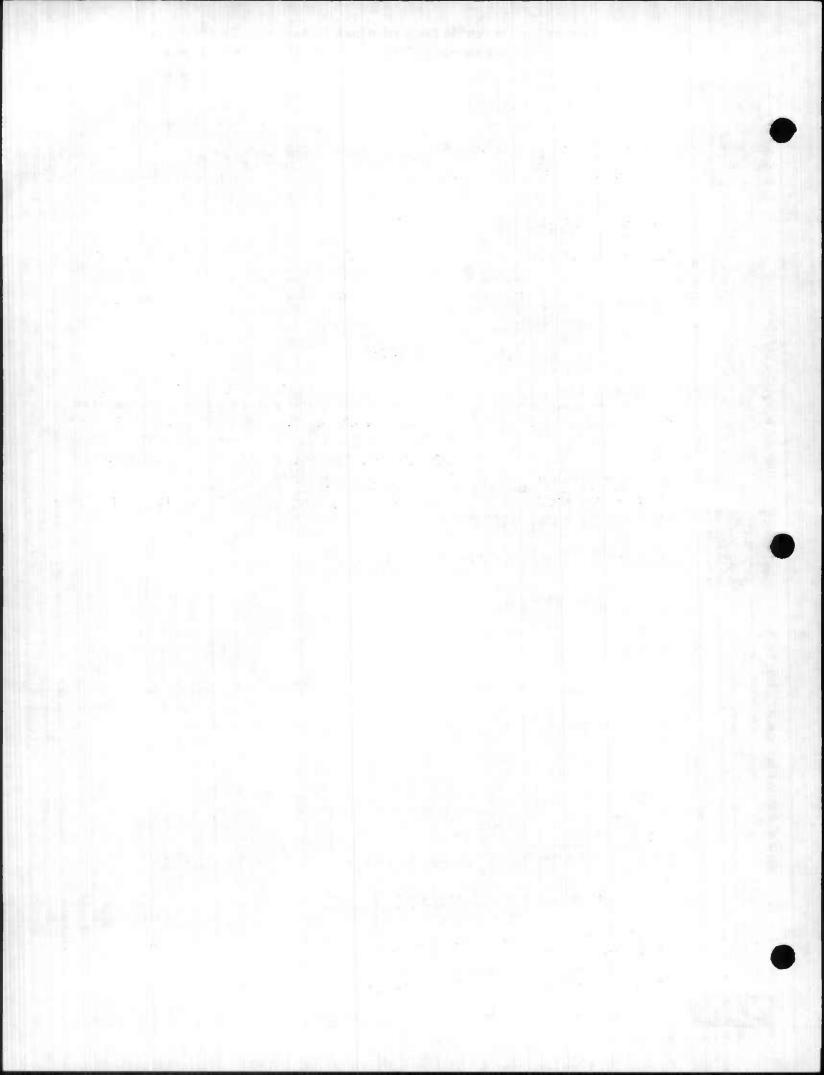
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State of Maryland / Department of Health and Mental Hygiene 9 268 | 6

					Cei	rtificate	of i	Death			Reg. No.				
61		1. Decedent'a Name (First, Middle, L	ast)			100				2. Date of D Month	Day Day	Year	3. Tima c		
Physicia /Medic		HARVEY RAYMO	OND CUSTI	S								1999	9 7:30	0AM	
Examin		4a Facility Name (If not institution, gi	ive street and number)				4	b. City, To	own, or Lo	ocation of Dea	ith 4c. (County of Deal	th		
<u> </u>		7130 POORHOI	ICE DOAD					LA	PLAT	'A	C	HARLES	5		
Funeral		5. Social Security Number 6.	Sex 7. Ac	e (In yrs. las	t birthday)	If Under		If Under	24 Hrs.	8. Date of B	irth		thplaca (State buntry)	or Foreign	
Director		214-28-5688	51X M 2□F	69	Yrs.	Months	Days	Hours	Min.		0ay, Year) 18, 19	29 AR	EDMORE,	PA	
		Usual Residence of Decedent											,		
ehow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	Olty Limits	
Mar He e	tor	MARYLAND CHARLE	ēS.	LA P	τ.ΔͲΔ								1 🗆 Yes	s 2 XNo	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street end Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?		
ath with the Maryla 23s or 28s-f show		7130 POORHOUSE F	CAO			2	0646	5			INT	TED STA	TES		
5-0020 T2 hours after death with the Maryland natural; or thems 23a or 28a-f ehow sited Examples mouthed at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1	1			lain? (Sp	ecity Yas or N		4. Rece - Ame			
Hero	F	1 Never Married 2 Namled	Armed Forces?		If Yes, specify Cuben, Mexican, Puerto							Biack, Whit	e, etc.		
21215-0020 d within 72 hours after deal giene. or then "netural", or thems in the me i	by	3 ☐ Widowed 4 ☐ Divorced	It Yes, Give Year or Detes:			1□Yes 2	No No	Specify.				Specify: BI	ACK		
72 hours	P	15. Decedent's E			16a Dece	dent's Usua	l Occup	ation			16b. Kin	d of Business	Andustry		
n 72 ho	Completed	(Specify only highest g	rade completed)		(Give	kind of wor. DO NOT us	k done	durina mos	st of work	ing			,		
within ene.	E	Elementery/Secondery (0-12)	College (1-4or :	5+)	PAST						MTN	ISTER			
		17. Father's Name (First, Middle, Las			12101	OIC		18. Moth	er's Name	e (First, Midd					
Vlan Wental Wental Irked o	Be		,										· C		
Should and Men ond Men on marke	2	RAYMOND CUSTIS			4.61 6.4 10		(0)					CUSTI			
	Health a Health a ther tra	19a. Informant's Name/Relationship										Town, State,			
C = 64 F		LE VURN CUSTIS /	WIFE			POORH sition (Nam		RUA	ם ט	A PLAT	7		20646		
Pages Pages of the mt: If its		20a. Method of Disposition 1 Buriel 2 Cremetion 3	☐Removal from Stete	cen	netery, cres	natory or of	her plea	ce)		Date	20G. LOG	eation - City or	rown, Stete		
Pag Pag Thent Int: H		4 Donation 5 □Other (Spec		WEST	LIBE	RTY C	HURC	TH CE	M. 8,	/20/99	MARI	RIOTTSV	TLLE,	MD	
Baltimore, semit, Pages 1 e Department of Hee mportant: If item any injury or othe	Departmen Departmen Important: any Injury once.	21. Signature of Funeral Service Lice	ingee S	2	22	Name and	Addre	ss of Facil	ity	MIT ID	71				
22 2 2 3		THORNTON FUNERAL HOME, P.A. 1439 LIVINGSTON ROAD INDIAN HEAD, MD													
	\dashv	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Physician		shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as carolac or respiratory arrest, Approximately arrest, Interval Between Onset and Death													
/Medical		tmmediate Cause (Final disease or condition PROSTATE CANCER													
Examiner		disease or condition resulting in death) PROSTATE CANCER													
make the	P P	Due to (or es e consequence of):													
pe led	Examiner	b .													
b, executed in and ial-transit	Xar	Sequentially list conditions, if any, leading to immediate													
X 68 /60, certificate be executed ding physician and se es the burial-transit		Cause (Disease or injury													
X 08/00.	edicai	that initiated events resulting in death) Last		Due to (or a	s e conseq	uenca of):									
X Contifficients	Me		I d												
0 2 2 3															
. 0 00	Physician	Pert II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	nderlying ca	use giv	en in Part	l.	23b. Did tobacco use contributs to the cause of d					
that the	£						1 Yes 2 No 3 Prob					robably 4	Unknow		
5 % 5	þ											T			
HECOLOS, ne law requires to a hes been signalige 2 should be											s en eutop	sy 24b.	Were autopsy available prior		
ecor law requ es been 2 shoul	Set												completion of of deeth?	cause	
The law ata hes page 2	Completed									10	Yes X	(No	1 Yes 2	¬ No	
VICAL The definers The centificate		25. Wes case referred to medical	T					00 DI	1 Da-1			2110	10103 20	7140	
Or VItal Physician: 7 this certifical ral director, p	Be	examiner?	Hospital:				Oth	OF.		h (Check only		Day (2	9.1		
Phys this	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ent 2 El	8b. Time o		A	4U N	ursing Ho	28d. Describ		Other (Spe	icity)		
SION tending leath. tor: After the fune	o l	1 Xi Naturel 5 ☐ Pending	(Month, Da		Injury	M	Bc. Injur Wor	k? Yes 2□	1 No	EUG. DUGGIID	o mon mjarj	00001700			
DIVISION I or Attending after death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not	he					165 2	1140	OOL Leasting	(Chanat and	d Alumbas as O	Luca I Davida Aliv	ma b a s	
or At aftar of Direct in by	E	4 Homicide determine	200. Place of inj	ury - At hom c. (Specify)	e, farm, str	eet, factory	, office				own, State)	Number or A	lural Route Nu	mper,	
led is a led															
f hour	edical	29e. Certifier 1 Sertifying P	hysician: To the best	of my knowle	edge, death	occurred a	in my o	ne, date a	nd plece,	and due to th	e cause(s)	and manner e	s stated. e to the cause	(s)	
		one)	and manner st												
To t To t	2	29b. Signeture end title of certifler 29d. License number 29d. t										signed (Mon	th, Day, Year)		
	- 1	1 Karull	- M.	110(h		D	2835	2		AUC	SUST 1	6, 19	99	
	ŀ	30. Name and address of person who	completed cause of a	death (Item 2	3a) (Type	Print)									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRUSHAN MATHIR. MD. P.O. BOY 1703 TA DIATA MD. 20646													
Stat	0	KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646 31. Date filed (Month, Dey, Year) 32. Registrar's Signature													
Registra				معسوي	B.	100		/							
•		AUG 1 7 19	1		/	170									

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9 26817

								Cer	tificate of	Death		Reg. No.	and land	0017	
100	Physician /Medical	ı	. Decedent's Nam Edward		osgrove						2. Date of D Month Augus	Day	Year 1999	3. Time of Death 3:05 am	
	Examiner				give street and num - Chesa		ke			4b. City, Town, or Arnold	Location of Dea		unty of Death ne Ari	undel	
	Funeral Director	0	. Social Security N 0 4 4 – 1 6 –	1452		-	In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of B (Month, D	irth ay, Year)	9. Birthp	place (Stete or Foreign ntry) SW York	
	the Maryland	1	Isual Residence of 0a. State NC	10b. County Moor	e	10	Oc. City, Tow Pine						1	10d. Inside City Limits 1 ☐ Yes 2X No	
	E 0 8 C	1	0e. Street and Nu	mber exfire	Drive				10f. Zip Code 283	74		10g. Citizen	of What Cour	ntry?	
5-0020	or the line of the		Marital Status Never Marr Widowed	ied 2□ Merrie 4 ☑ Divorced	12. Was Dece Armed For 1 1 Yes If Yes, Giv Year or Da	rces? 2 No	erin U,S.		Vas Decedent of I Yes, specify Cut ☐ Yes 2 No	Hispanic Origin? (Sean, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		Race - Americ Black, White, ecify: White	etc.	
21215-0	wid be filed within Mental Hyglena. Irked other than " stic avant, the Men	-	(Special Control of Co		Education grade completed) College (1	-4or 5+)	16a.	(Give I life. D	ent's Usual Occu kind of work done O NOT use retire lanager	during most of wor	rking		of Business/In	dustry Supplies	
Maryland	# I 8 6	1	7. Father's Name Unkno		st)					18. Mother's Nar Sadie	me (First, Middle Broo		mame)		
	2 sh and aum		9a. Informant's Na Ken Co	ame/Reletionship						r Lane				D 21146	
Baltimore,	it. Pages 1 and 2 should be fill riment of Health and Mental H ritent; if Item 27 is marked out highry or other traumatic aven To Be	2	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20c. Location - City or Town, State Aug 11 Baltimore, MD												
Balt	Departicular Depar	-	1. Signifure of Fu	Ingral Solvice L	au			Ba 4 9	Name and AddreSTRANCO 5 GOV.	& Sons Ritchie	P.A. Hwy.	Fune: Seve:	ral Ho	ome ark, MD	
-4	/Medical		mmediate Cause ((Final						ing, such as cardiac			Toke	Approximate 4 6 Interval Between Onset and Death	
		Due to (or as a consequence of):													
60,	be assecute cian and burial-tran		equentially list co any, leading to in ause. Enter Unde ause (Disease or	anditions, nmediate orlying Injury	C	Du	e to (or as a	conseq	uence of):						
Box 68760,	hyprician and wedical Examiner burd-learning the burd-learning the burd-learning the burd-learning b	6	hat initiated events esulting in death) (5	■ d	Due	e to (or as a o	consequ	eence of):						
, P.O.	that the death ned by the atte detached for V Physicia	P	art II. Other algorit	Hensi'd	contributing to de	ath but n	not resulting in	n the un	derlying cause gi	ven in Part I.		l tobacco use		o the causa of death?	
Records	v requires that the death been signed by the atter should be detached for leted by Physicial	-	Die	ease	_, d	ys	pho	8	10,0	Shasio		s an autopsy formed?	av	ere autopsy findings vailable prior to empletion of cause death?	
_	ician: The law certificate has rector, page 2 Be Comp	2	5. Was case refer	red to medical	my +	-00	22	te	edin	26. Place of Dea		Yes 200	No 1[☐ Yes 2☐ No	
1 <	2 00 2		examiner? 1 ☐ Yes 2	No	Hospital:	patient	2 ER/Ou	rtpatient	3□ DOA Ot		iome 5□Res		Other (Special	(y)	
0 1	fer this meral di	2	7. Manner of Deat	h 5 ☐ Pendino	28a. Date o	f Injury		Time of	28c. Inju		28d. Describe			-7-47	

To the Hospital or Attanding P within 24 hours after death.

To the Funeral Director: After I completely filled in by the funeral

Medical Certification

5 Pending investigation

1 Neturel
2 Accident
3 Suicide 6 Could not be determined 4 Homicide

(Month, Day Year)

1 Yes 2 No 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

479

31. Date filed (Month, Day, Year)

AUG 1 2 1999

32. Registrar's Signature

Registrar

State

The second

AUG 1 2 1993

3. TIME OF DEATH 7:25

1 XYES 2 NO

Approximate Interval Batween **Onset and Death** US

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 _ YES 2 _ NO

place, and due to the cause(a) and menner as stated. 29d. DATE SIGNED (Month, Day, Year)

mon

BIRTHPLACE (State or Foreign Country)

14. RACE — American Indian, Black, White, etc.

AM

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Ralph Crowner

BAL	death	4
m	fter	· Alba
	55	1
	10	73
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, O	withi	mindal
<u>4</u>	thed	-
5	DOC	and.
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	IE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	or second commences and a second to the few forms of the few seconds and a second to the few few few few few few few few few fe
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	ш	

31. DATE FILED (Month, Day, Year)

AUG 1 6 1999

		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. In:	st birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	1	BIRTHPLA	CE (State or For
	- 8	213-05-00	15	1 XM 2 - F	78	YRS.	MONTHS	DAYS	HOURS MIN.	Dec.	13,19	20 M	arvl	and
pino		9a. FACILITY NAME (If not is		treet and number)			9b. CITY. 1	TOWN C	OR LOCATION OF DE				Y OF DEATH	
3 should	Œ	Millenniu	n Hea	lth & R	ehab		ਸ਼ੁਰ	lapi	water			Anne		
1, 2,	15	RESIDENCE OF DE					110	igev	Water			L		
physician. burial-transit permit. Pages 1, 2,	DIRECTOR	Maryland	10b. COUNTY	Arund	٥١		r, TOWN OR							I. INSIDE CITY LIMITS?
Ę.				e Al una	61	An	napo							XYES 2 🗌
alt per	FUNERAL	701 Glenwe		+				101.	21401			10g. CITIZE		COUNTRY?
trans	N I	11. MARITAL STATUS	50a b	_	IT EVER IN U.S. AF	MEO	1 42 144	M.C. DEC	ENDENT OF HISPAN	10 00101	In the sale. We			American India
	BY FU	1 Never Married 2 3 Widowed 4 Divi		FORCES?	MAR OR DATES		lf.	yes, spe	ecify Cuban, Maxica 2 NO Specify	n, Puerto		or No.	Black, WI	
or attending r use as the	E		CEDENT'S EDU		16a. Di	ECEDENT'S	USUAL OCC	CUPATIO	ON set of working	182	. KIND OF BUS	SINESS/INDU		
for u	COMPLET	Elamentary/Secondary (College (1-4 or 5	+)	. Do NOT us	e retired.)	anny mo	ing most of working					
by the hospital of the detached for at once.	JG	6th		0		Wate	rman			5	Self E	Emplo	yed	
detach once.	ő	17. FATHER'S NAME (First, A	Aiddle, Last)						18. MOTHER'S NA					
	BE C	Robert Cr	owner	Sr.					Elenor	Day	ris			
5 should		19a. INFORMANT'S NAME (15	b. MAILING	ADDRESS	(Street a	and Number or Rural F			n, State, Zip C	code)	
	70	Elenor Co	bbs(S	ister)	5	200	12th	St	t. N.E.	Wa:	shing	ton D	.C.	20011
leath, Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSIT DO Burial 2 Cremati Donation 6 Othe	on 3 🗆 Ram	oval from State	20b. PLACE other p Anna	of dispos poli	S Me	ne of cen	metery, crematory or rial Ga:	rdei	20c. LO	cation - ci	ty or Town,	State
Pag al dir		21. SIGNATURE OF FUNERA	AL SERVICE LIC	CENSEE			22. N	AME AN	ND ADDRESS OF FA	CILITY				
		Lan	- 13	Ree	. 0		Wm	. R	Reese & Rest St.	Son	s Mor	tuar	y, P	.A. 21401
e be executed within jours after sician and completely filled in by the rior to burial, cremation, or removal traumatic event, the medical	NOI	23. PART I. Enter the cahook, or I IMMEDIATE CAUSE (FI disease or condition resulting in death) Sequentially list condition, and it is any, leading to immediate the candidate of the candidate	neart failure.	a, DUE TO	Congu	otive utiv	te s		failu ep ap					Approximating interval Be Onset and
th certificate anding physiene p Hygiene p	CERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS	TING ury ST	d	O (OR AS A CONSE								1	
v requires that the been signed by I and It. of Health and I shows any In	AN: MEDICAL	PART II, Other algorific	ant condition 2 I WHEN	an contributing to	E Me	CLI +	in the und	dariying	g cause given in	Part f.	24a. WAS AN PERFOF 1 TYES 2	RMED?	CO OF	RE AUTOPSY FINALABLE PRIOR MPLETION OF CODEATH?
The law te has b are Dept.	CIAI	25. WAS CASE REFERRED	TO MEDICAL	0.	J				LACE OF DEATH (Ch	eck only o	ne)			
		EXAMINER?		HOSPITAL:	☐ ER/Outpatlant	3 🗆 DOA	OTHER		ne 6 🗆 Residence	6 🗆 Oth	er (Specify)			
certificat the Sta	PHYSI	27. MANNER OF DEATH		28a. DATE O	F INJURY	28b. TIM	E OF	26c. INJ	JURY AT		SCRIBE HOW I	NJURY OCCL	JRED	
NG PHYSICIAN: ther this certific eath with the Si marked, or II	ВУР	1 Natural 5 2 Accident	Pending Investigation	(Month,	Day, Year)	IN	M		YES 2 NO					
TTENDI TTOR: A after do	8	0 0 0 1-11	Could not be determined	26e. PLACE building	OF INJURY — At h	ome, farm,	street, facto	ery, offic	i a		CATION (Street or Town, State)		r Rural Route	Number,
世 当な =	COMPLET	anal only		E					and place, and dua feath occured at the					d manner as st
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITL	E OF CERTIFIE		m		-		29c. LICENSE NUR D481	MBER D	1	29d. DATE	SIGNED (Mo	onth, Day, Year)
	2	30, NAME AND ADDRESS O	E-PERSON WI	O COMPLETED CAL	ISE OF DEATH (IT	M 27) (7ma	Print)						-	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

TO A DO Chambers MD 18334 F

32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

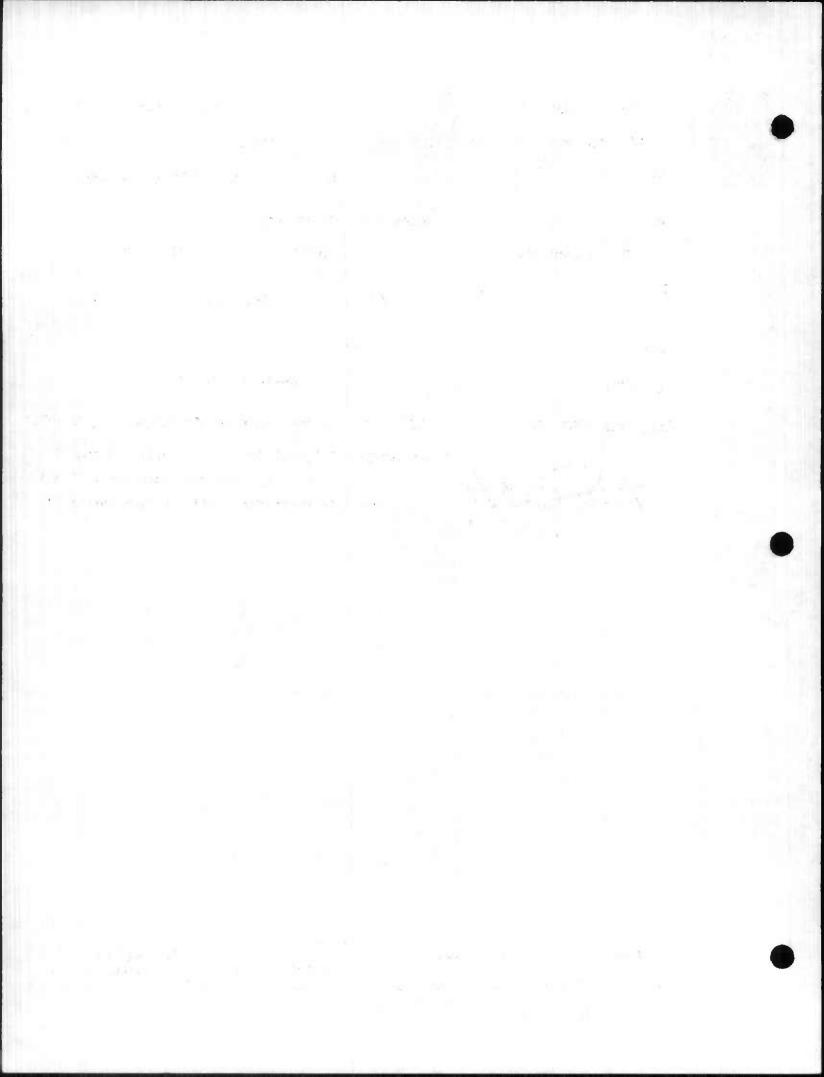
2. DATE OF DEATH MONTH DAY

12

1999

8

					State	i waryiai				Death	wentai ny	Reg. No.	9 2	681	9	
	Physic /Medi		1. Decedent's Neme (First, Mic JOSHUA IS	AAC	CRUZ						2. Dete of De Month JUL	Day	Year 9	3. Time of 5:5.	of Death 5 AM	
	Exami		4e. Facility Name (If not institut							4b. City, Town, or		h 4c. Count	y of Death			
	Funeral Director		NATIONAL 5. Social Security Number N/A	6. Ser		7. Age (In yrs		y) If Uno Month	der 1 Year is Deys	Hours Min	8. Dete of Bi	rth ay, Year)	9. Birthpi Count Mary 1:	ace (State o	or Foreign	
	Du &		Usual Residence of Decedent 10a, State 10b, Cour	ity		10c. C	ity, Town or	Location					10	Od. Inside C	lity Limits	
	f sho	ō		.G.			1		ir Fo	rce Base					2 XNo	
	23a or 28a	al Director	10e. Street and Number 2078 B Tuc		Ave				Zip Code	0762		10g. Citizen of United				
020	/z hours ener death with the maryland hatural', or thems 23a or 28a-f show pical Examiner must be nutified at	by Funeral	11. Maritel Status 1 Never Married 2 M 3 Widowed 4 Divorce	arried	Armed F	2 No ive X No	J,S. 13	If Yes, s	cedent of I pecify Cub 2 No	Hispanic Origin? (Sean, Mexican, Puer Specify: Po	Specify Yes or Note Rican, etc.)	Bie	ce - America eck, White, e		4	
	within /z nours piene. r than "natural", tra Maxical Era	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12 N/A	nest grade	cetion		/Giv	edent's U ve kind of DO NOT	sual Occur	pation during most of we	orking	16b. Kind of E	Business/Ind	ustry		
and 2	os med other ovent,	To Be Co	17. Fether's Neme (First, Middle Billy Cruz	e, Last)					.1/ 4.1	18. Mother's Name (First, Middle, Maiden Surname) Christy Boldin						
ary	PEE	F	19a. Informant's Name/Relation	nship (Ty	pe, Print)	<u> </u>	19b. Ma	lling Addre	ess (Street	t and Number or R	ural Route Numb	er, City or Town	n, State, Zip	Code)		
Z :	= N -		Billy Cruz (F)	THEF	2)					Ave, An	drews A	ir Force	e Base	,MD 2	0762	
more	nent of int: If it iny or o		20a. Method of Disposition 1 Burial 2 K rematto 4 Donation, 5 Other		emoval from	State L	Place of Disposers, cree Cre	position (from atory of amatory of amator)	lame of rother pla ry Ju	œ) ily24,199	-	y or Town, Stete ,Maryland				
Dan	Departr Imports any inje		23a. Parts Enter the disease, or complications that unique the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,													
	hysician /Medical		23a. Parte Enter the disease, shock, or heart failure. L	or compos st only or			th. Do not e	nter the m	ode of dyi	ng, such as cerdia	c or respiratory	rrest,		Approximat Interval Bet Onset and	tween	
	xaminer	Je.	disease or condition resulting in death)	8			or as a cons	- IIII					I I			
oʻ	physician and s the buriel-trensit	Examiner														
- :	nding physical	Medical	Cause (Disease or injury that initiated events resulting in death) Last			Due to (or as a conse	equence o	f):			-				
POX	e attending p	slan														
ָ יָ	by the	/ Physician/M	Part II. Other significant condi	tions con	tributing to d	leath but not re	sulting in the	underlyin	g cause gi	ven in Part I.		tobacco use co Yes 2∑No				
or Vital Records	is been sign	Completed by									24a. Was	an eutopsy ormed?	con	re autopsy illable prior t npletion of d leath?	to	
	ate h page	Com									1)()	Yes 2□No	1 🗆	Yas 20] No	
OI VIII	is certificate director, pa	Be	25. Was case referred to medi examiner?		locaital:				100		eth (Check only	one)				
	this did	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident inves		28a. Date		28b. Time Injury	of	28c. Inju Wo		Home 5 Res 28d. Describe	idence 6 Ot how injury occu)		
DIVISION	hin 24 hours after deeth. the Funeral Director: After ripletely filled in by the funer	Certification:	3 Suicide 6 Cou		28e. Place build	e of Injury - At h ing, etc. (Speci	ome, ferm, s	street, fact	ory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rural	Route Nun	nber,	
	within 24 hours after d To the Funeral Direct completely filled in by	edical (29a. Certifier Check only one) Certifier 2 Medic	ring Phys al Examir	er: On the b	e best of my knowasis of examination	owledge, dea ation and/or	ath occurre	ed et the ti	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	nanner as sta , and due to	ited. the ceuse(s	s)	
1	with To the	Σ	29b. Signeture end title of certi	ier				2		se number		29d. Dete signe	ed (Month, E	ay, Year)		
			Per, CR				m 23a) (Type	e, Print)		1551 TIONAL N	AVAL MEI	O7/2	23/99 ENTER	P	Political designation of the second	
	Sta	to	RUSSELL R. MC			LTC, 1		A	BE	THESDA M						
	Registr	_	JUL	26	1999	bene	ner	19.	de	racker						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time = Deeth 1 Decedent's Name (First Middle, Last) clemons **Physician** Reginald 1=:34 m July Burton 22 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, giva street end number) Examiner CITY HOPKINS 6. Sex HOSPITAL BA HIMCRO
r If Under 24 Hrs.
s Hours Min. Baltimore City THE JOHNS 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete di Birth (Month, Dev. Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1X M 2□ F Months Deys Yrs. 33 Aug. 25,1965 Washington DC Director 219-98-5760 Usual Rasidence of Decedent with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Prince George's Beltsville 1 Yes 2 No Directo 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20705 11232 Evans Trail Apt T-1 U.S.A. Funeral death 14. Rece - Amarican Indian, Bleck, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours effert Department of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or iten any injury or other traumetic event, the Medical Evantine once. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Navar Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) 12th N/A N/A N/A 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Robert B. Clemons Helen Johnson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Robert B. Clemons (Father) 912 Pocahontas Drive Ft. Washington, MD 20744 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition July 28. 15 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Resurrection Cemetery 1999 Clinton, Maryland 22. Name end Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 ort1. Enter the disease, of complications (at caus hock, or heart feilure. List only one cause on each used the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical pulmopary embolus 30 MINUTES Examiner Due to (or es e consequence of): Physician/Medical Examiner deep venous thrombosis 5 days that the death certificate be executed physician and the buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) 98 950 ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 N Unknown signed b p 24b. Were autopsy findings evalleble prior to complation of cause of deeth? 24e. Wes en eutopsy performed? Completed his certificate hes but director, pege 2 st 1 M Yes 2 No 1 Tes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥ Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27 Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Netural 5 Pending death. 1 Yas 2 No investigation 2 Accident after death Director: 6 ☐ Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directon pletely filled in b. 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licensa number resident physician 7140 RES-000 July 22, 1999

State Registrar

31. Data filed (Month, Day, Year) 2 6 32. Registra/s Signeture

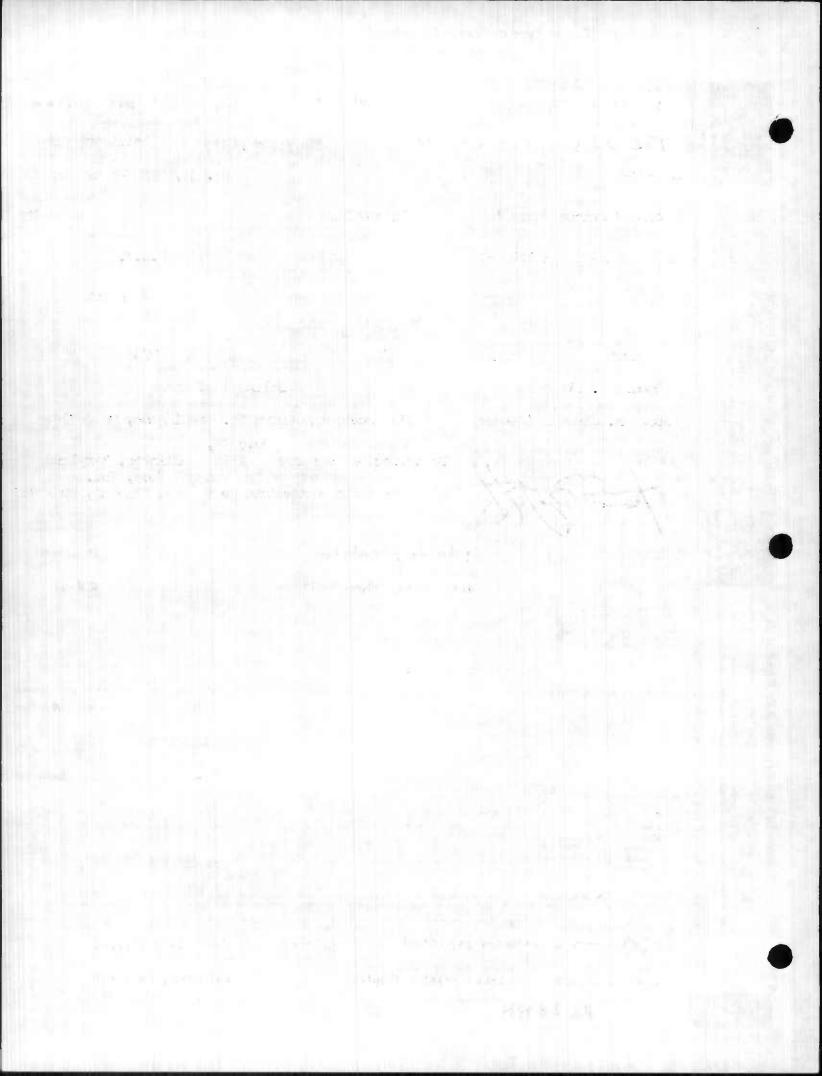
Johns Hopkins Hospital

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Diane KIEIN, MO

oaks

Baltimore, marylano

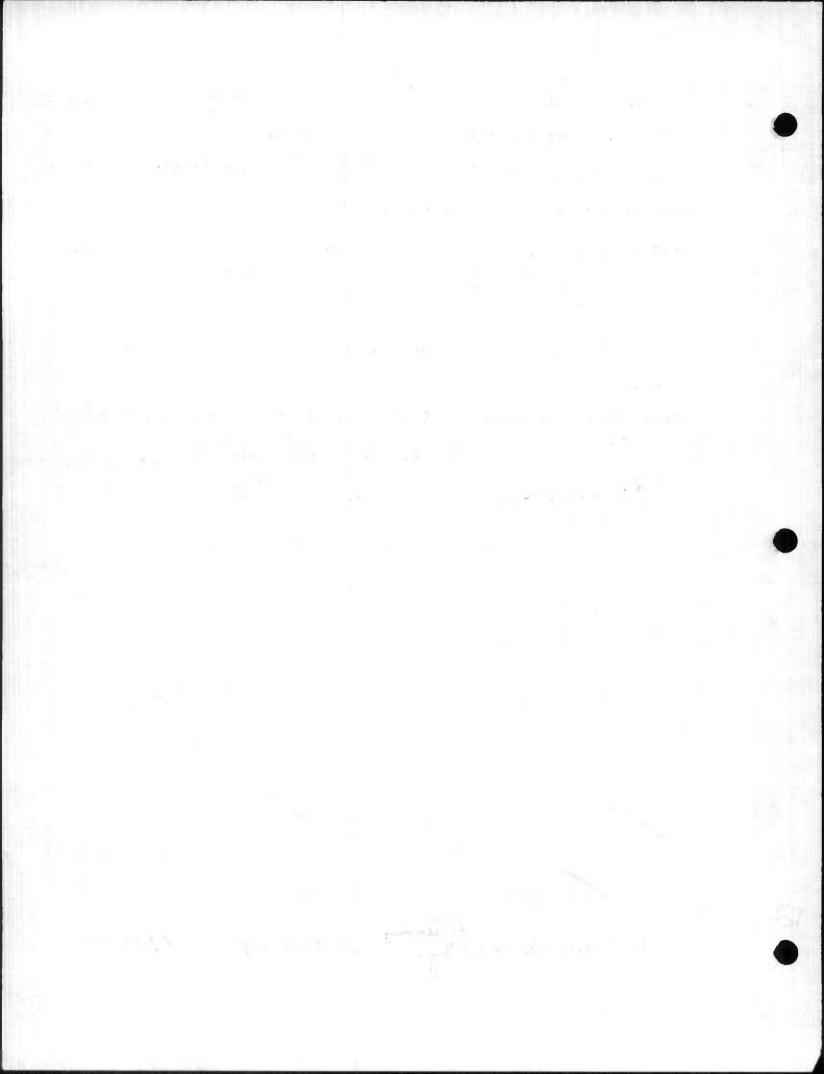


	1. Decedent's Neme (First, Middle, Last)	Certificate of	Death 2. Date of	Reg. No.	3. Time of Death			
hysician /Medical	Richard Co.	llins	Month July 4b, City, Town, or Location of De	21, 199	99 0525			
xaminer neral ector	Anne Arundel Medical Center 5. Social Security Number 213-34-4433 Anne Arundel Medical Center 6. Sex 150 M 20 F 68	cal Center		Anne Ar				
	Usual Rasidance of Decedent 10a. Stata 10b. County 10c. Ci	ity, Town or Location			10d. Inside City Limita			
be notified at Director	Maryland Anne Arundel	Edgewa	ter	1 □ Yes 2 🔀				
		037	10g. Citizen of Wha	at Country?				
by Funeral	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:	J,S. 13. Was Decedent of I- If Yes, specify Cubi	tispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, atc.) Specify:		Amarican Indian, Whita, atc. Black			
Completed	15. Decedent's Education (Specify only highest grade completed) Elementacy/Secondery (0-12) College (1-4or 5+)	16a. Decedent's Usual Occup (Giva kind of work done lifa. DO NOT use retired Laborer	ation during most of working d)	16b. Kind of Busin	NC-SOLISI			
To Be C	17. Father's Nema (First, Middla, Last)	lins	18. Mother's Nama (First, Midd Edith L.	dle, Maiden Sumama) Brown	AL MARKET			
-	19a. Informent's Name/Ralationship (Type, Print) Charles D. Collins/Brother		and Number or Rural Routa Nur Road Edgewater					
	Mad Burial 2 Deramation 3 Dramovel from Steta	Plece of Disposition (Nama of cematary, cramatory or other placeness UM Church		20c. Location - Cit				
	21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Freder							
o paraminer with the control of the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants rasulting in death) Last	or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): Meli	litus		days			
Physician/Me	Pert II. Other significant conditions contributing to death but not rec	ven in Part I. 23b. D	b. Did tobacco use contribute to the cause of death					
-	1 1.		1	☐ Yes 2☐ No 3	Probably 4 Unknown			
	Unemia				()			
þ	unemia			as an autopsy artormed?	24b. Were autopsy findings available prior to completion of cause of death?			
e Completed by	25. Was case rafarred to medical		1 l	□ Yas 2) (No	available prior to completion of cause			
To Be Completed by	25. Was case rafarred to medical axaminar? 1 Yas 2 Solvo 27. Mannar of Death 1 Statural 5 Panding 28a. Data of Injury (Month, Day Year)	ER/Outpatient 3 DOA Oth 28b. Tima of Injury M 1	26. Place of Deeth (Check on the control of the con	□ Yas 2 00 No	available prior to completion of cause of death? 1 Yas 20 No			
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edicai Certification: To Be Completed by	25. Was case rafarred to medical axeminar? 1 Yas 2 Solvo 27. Mannar of Death 1 Statural 5 Panding (Month, Day Year) 28a. Data of Injury (Month, Day Year) 3 Sulcide 6 Could not be detained to be detained to be detained.	28b. Tima of Injury M 28c. Injury Worldon, farm, street, factory, office by owledge, death occurred at the time.	26. Place of Deeth (Check on Deet) 27. Place of Deeth (Check on Deet) 28. Place of Deeth (Check on Deet) 4 Nursing Home 5 River (Check on Deet) 28. Describe (Check on Deet) 28. Location (Check on Deet) 28. Location (Check on Deet) 28. Describe (Check on Deet) 28. Describe (Check on Deet) 28. Describe (Check on Deet) 28. Describe (Check on Deet)	arlormed? Yas 2) dNo ly one) esidence 6 Other to be how injury occurred In (Street and Number Town, State)	available prior to completion of cause of death? 1 Yas 20 No (Specify) or Rural Route Number,			
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			State of Maryland / De	epartment of Certificate of		500	ene 99	26822		
	Physici /Medio		1. Decedant's Nama (First, Middla, Last) Marion E. Cole				Day 1999ar	3. Time of Death 905 PM		
	Examir		4e. Facility Nema (If not institution, give street end number) Solomons Nursing Center	4b. City, Town, or Lo Solomons	City, Town, or Location of Deeth olomons 4c. County of Death Calvert					
	Funeral Director		5. Social Security Number 6. Sex 7. Aga (In yrs. last birtho	Months Days		8. Data of Birth May	9. Bir Ma	hplace (Steta or Foraign writh 1 and		
Baltimore, Maryland 21215-0020	a-f ahow	ctor	10a. Stata Maryland Calvert 10c. City, Town o					10d. Inside City Limits 1 ☐ Yas 2 ☐ No		
	ter death with the Marylan frems 23s or 28s-f show free must be notified at	rai Director	10e. Street and Number 13325 Dowell Road	10f. Zip Coda 2068						
	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show solical Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Giva Yaar or Dates:		3. Was Dacedent of Hispanic Origin? (Specify Yes or Nolif Yas, specify Cuban, Maxican, Puarlo Rican, atc.) 1□ Yas X□ No Specify: 1□ Yas X□ No Specify:					
	within ene.	Completed	ciementery/Secondary (0-12) Collega (1-4or 5+)	ecedant's Usuai Occu Giva kind of work done fa. DO NOT use retin	ccupation ona during most of working stired)		Sb. Kind of Business			
	be filed tal Hyg d other event,	To Be C	17. Fathar's Nama <i>(First, Middla, Last)</i> unknown		18. Mothar's Nama (First, Middia, Maiden Surnama) unknown					
	alth and 27 is m r traum				on Pt. R	Rural Routa Number, City or Town, State, Zip Code; 678 Rd. Prince FRederick MI 22 Date 99920c. Location - City or Town, Stata Service Alexandria Virgin				
	permit. Pages 1 a Department of Hei Important: If Hem any injury or othe		20a. Method of Disposition 1	isposition (Nama of crematory or other place) olitan F	unera Se	fvice A	oc. Location - City or Lexandri	Town, Stata a Virginia		
	Physician /Medical Examiner		Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, Interval and Interval Cause (Final disease or condition rasulting in death) Rausch Funeral Home Appropriately arrest, Interval and Interval Appropriately arrest, Interval							
Records, P.O. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	n/Medical Examiner	Sequantially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disasas of injury thet initiated avants resulting in death) Lest b. Dua to (or as a condition of the c							
	the death by the atte	Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the	ia undarlying ceusa g	liven in Part I.	23b. Did tob		to the cause of death?		
	The law requires that the de ate has been signed by the a page 2 should be detached i	Completed by P	Hyperleni-		24a. Was an autopsy performed? 24b. Wara availa comp of dea			Wara autopsy findings available prior to complation of cause of death?		
Vital	certific irector,	o Be C	25. Wes casa refarred to predical axaminar? 1 Yas 20 No Hospitel: 1 Inpatient 2 FR/Output		ther	(Check only one)				
on of	After fune	⊢	27. Manne of Death 28a. Deta of Injury 28b. Tim	ER/Outpatient 3 DOA Winsing Homa 5 Rasidence 6 Other 28b. Tima of Injury at Work? M 28c. Injury at 28d. Dascribe how injury occurred				cify)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Sulcida 6 Could not be datermined 28a. Place of Injury - At homa, farm building, atc. (Specify)	, street, factory, office	ffice 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
7	he Hospi in 24 hou he Funer pletely fill	ledicai	29e. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.							
	To T To 1	Σ	29b. Signatura end titla of ceriffiar Alland Alland Alland Alland	P 29c. Licen	(94 d	290	7/221	0 -		
			30. Nama and addrass of person who completed ceuse of death (Itam 33a) (Ty	pe, Print)						

Registrar

31. Deta filad (Month, Day, Year)
JUL 2 2 1999

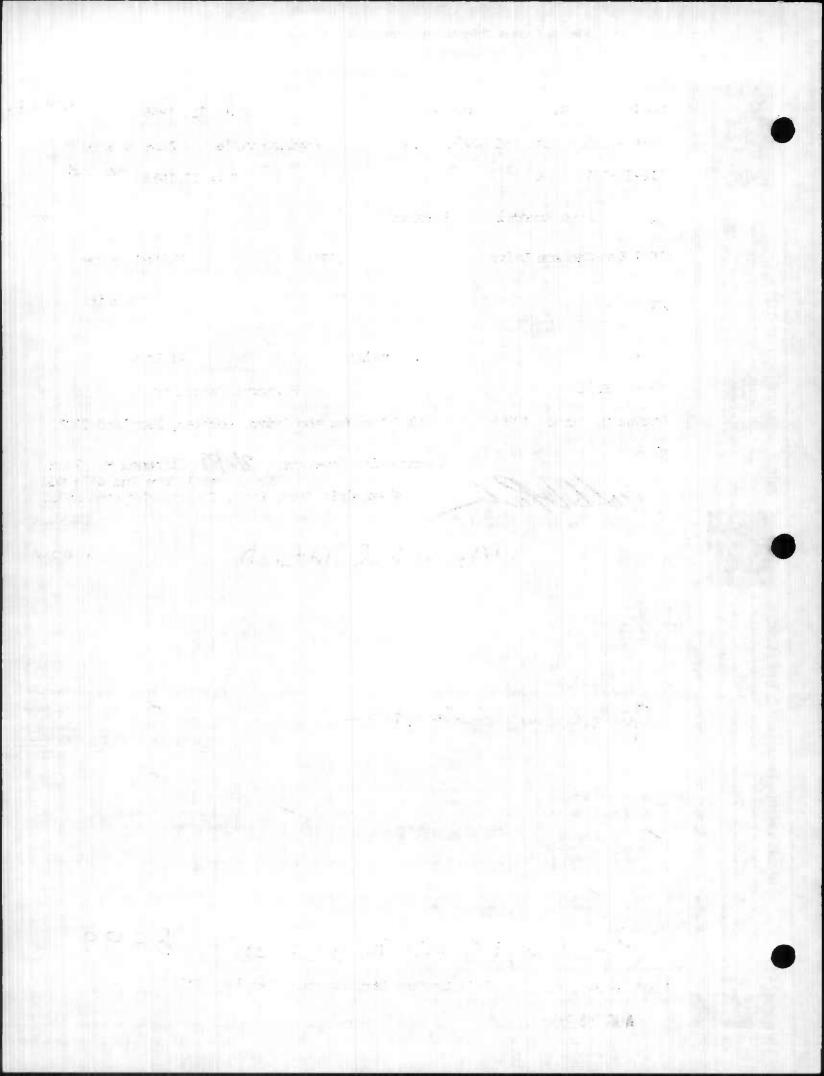


State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name /First, Middle, Last) **Physician** 5:00 A.M. Marie July 31 4b. City, Town, or Location of Death 31, 1999 /Medical 4c. County of Death 4a Facility Name (If not institution, giva streat end number) Examiner Kris - Leigh Assisted Living Home Davidsonville
| If Under 24 Hrs. | 8. Data (Mont Anne Arundel If Under 1 Year 9. Birthplace (Steta or Foreign Country) New York 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dev. Year) **Funeral** Days 1 M 2 XF 86 Yrs 116-12-1570 Director July 13,1913 Usuai Residence of Deceden with the Meryland 10a. Stata 10c. City, Town or Location 10d. inside City Limits 10b. County item 27 la marked other than "natural", or itama 23a or 28a-f ahow other traumatic evant, the Medical Examinar must be not that Anne Arundel 1□Yes 2□No Lothian Directo MD 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1007 Lee Jackson Drive 20711 Funeral United States death permit. Peges 1 and 2 should be filed within 72 hours effer deal Deperment of Heelth and Mentel Hygiene. Important: if them 27 le marked other than any injury or other trainer. 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3℃Vidowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surname) Thomas Reilly Margaret Carpenter 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Arthur R. Campli (SON) 1007 Lee Jackson Drive, Lothian, Maryland 20711 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 8/2/99 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of FecilityLee Funeral Home, Inc 6633 Old 21. Signatura of Funaral Supriou L Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 how Examiner Due to (or as e consequence of) Examiner ettending physician and for use es the bunel-transit certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disaasa or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as e consequenca of): 98 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part i. 23b. Did tobacco use contributa to the cause of death? Choleupti 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy page 2 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☐ No After this 27. Manner of Death Innerel 28d. Describe how injury occurred 28b. Time of 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 5 Pending Investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 6 4 Homicide Hospital 24 hours 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and mennar as stated. within 24 hor To the Fune completely fi Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and mannar stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature my title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 10 raul 1667 Crofton Ctr. Crofton, Maryland 21114 31. Data filed (Month, Dey, Year) 32. Registrar's Signeture

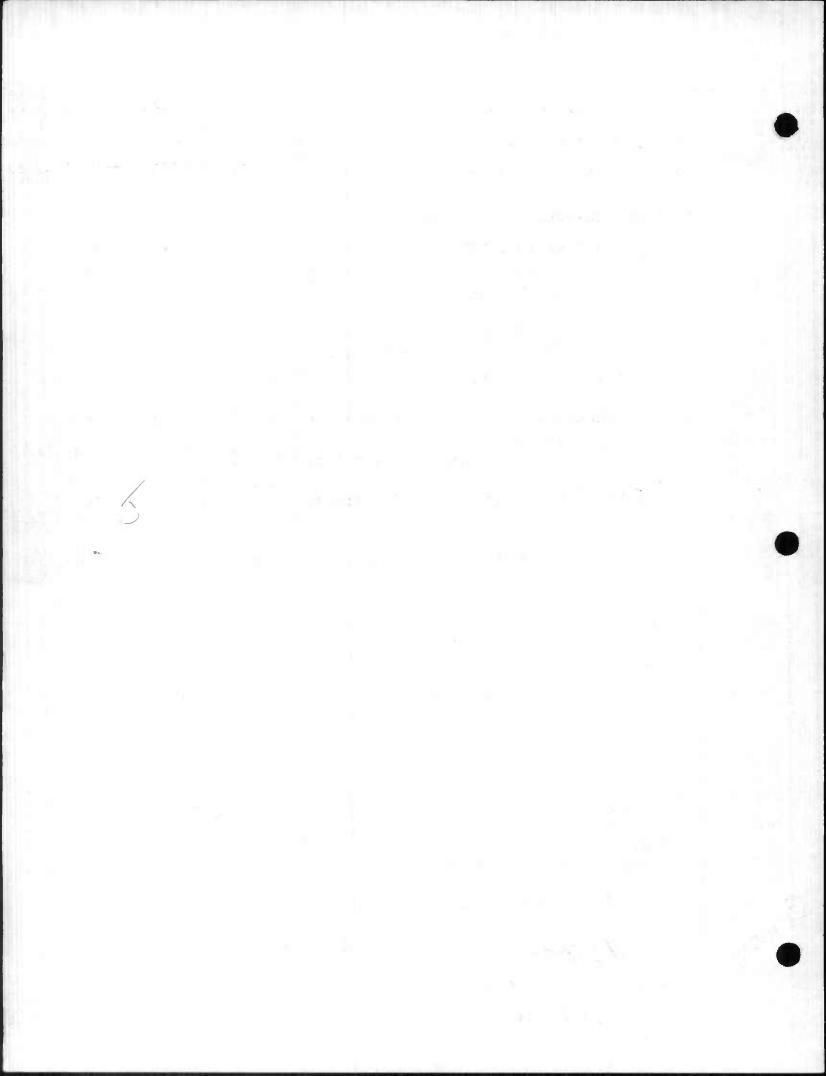
State Registrar

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Registrar's Signeture 9. Sports



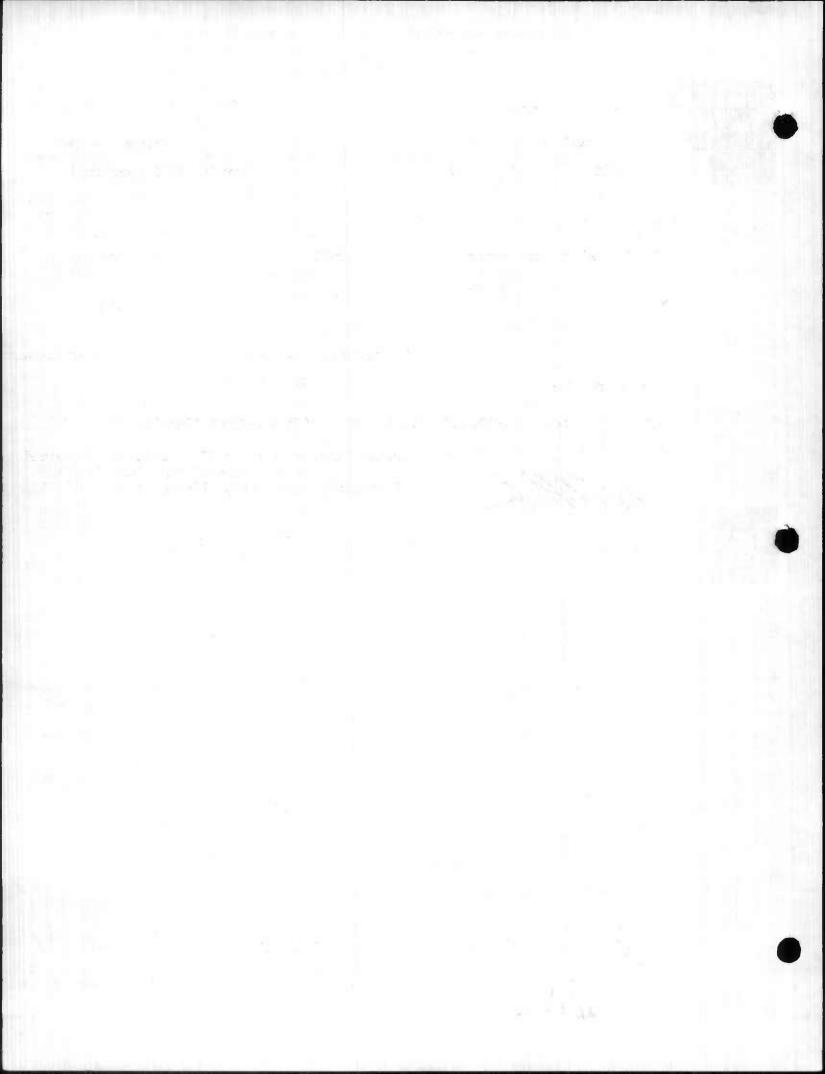
			State of Maryland / Department of Health and Mental Hygiene 9 9 2 6 8 Certificate of Death Reg. No.								002	i,	
	1. Decedant's Nama (First, Middle, Last) Physician Tamos Morris Cook Tr					2. Data of De Month	Dav	Year	3. Tima of I	Death			
	/Medi		James Morris Cook, Jr.				July2	8 1999		707	PM		
	Examir	ner	4a. Facility Nama (If not institution, giva s	The state of the s				4b. City, Town, or	Location of Death				
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	Funeral Director		219 30 9420	tm 2□ F 59	In yrs. last birtho	Month s.				8 Year) 9 3 9	9. Birthp	laca (Stata or Vir	Foreign gini
	and w		Usual Residence of Decedant 10a. Stata 10b. County	1	Oc. City, Town of	or Location					10	0d. Inside City	v Limits
	Mary 1 sh	Į.	Maryland Calvert	=	Lusby							1 🗆 Yas	
	h with the 3a or 28a st be noti	Funeral Director	10e. Sfreet and Number 50 Appeal Lane	1 Lane Apt. 322 10f. Zip Coda 20657			1			of What Country? ed States			
21215-0020	s within 72 hours after death with the Maryland ilene. Then "natural", or Hems 23a or 28a-f show the Maciest Evanting must be notified at		11. Marital Status 1 Nevar Marriad 2 Marriad 3 Widowed 4 Divorced	12. Was Decedant Ev Armed Forcas? 12 Yas 2 140 If Yas, Giva 5 Yaar or Datas:	ar in U,S.	If Yas, sp	cedant of loecify Cub	Hispanic Orlgin? (Sean, Maxican, Puer Specify:	Specify Yas or No to Rican, atc.)	Blac	e - Amaric ck, Whita, a	atc.	
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121	Hygiene. Hygiene. ther than "	mpi	Elemantary/Secondary (0-12) 1 2	College (1-4or 5+)						M			
2	등 수 등 부				LII	ick d	rive	T	ma /First Middle	Trans		ation	
an	S a s S	Be C	17. Father's Name (First, Middle, Last) James Morris Co	ook, Sr.				Madeli	me (First Middle, ne Leg	gett	161/		
Maryland	0 6 6 2	To	19a. Informant's Name/Reletionship (Typ Nora M. Cook— Wi					and Number or R					
Baltimore,	Pages 1 and 2 ment of Health tant: if Nem 27 jury or other tri		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from Stata	20b. Place of D cematary, larylar	cramatory o	r othar pla	ns Ceme	Data 3 1999 Etery	20c. Location - Chelte:	City or To	wn, Stata Mary	land
Balti	permit. Pages Department of Important: If It any injury or once.		21. Signature of Fundamental Service License	na A Col		22. Nama	and Addr	ass of Facility Ra	usch F	uneral	Hom	е рА	
			23a. Part1. Entar tha disaasa, or complishock, or heart fallura. List only on	cations that caused th							Pubi	Approximata	
	Physician /Medical Examiner	ı		Metan		Le	ung	Col			4	Interval Betwonset and D	
	death certificate be executed e attending physician and od for use es the bunel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasas or injury that initiated events rasulting in death) Last	Du	ue to (or as a con								
	death e atte	icia	Part II. Other significant conditions con-	tributing to death but i	nof resulting in the	ha undarivino	causa di	van in Part I	23b. Did 1	obacco use co	ntribute to	the cause o	f death?
, P.O	thet the ed by th detache	by Physician/M							Yes 2□ No	3 Prot		Unknown	
Records,	2 S E	Completed t							performed? availab		ere sutopsy fir aliable prior to mpletion of ca death?)	
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5	Physical distribution	7	10 143 220 110	ospital:			DUA		Homa 5 Hasia			1)	
E C	Sec. 26.	lon	27. Mennar of Death 1 Natural 5 □ Panding	28a. Data of Injury (Month, Day Y	(ear) 28b. Tin	ıry	28c. Inju Wo		28d. Dascribe I	now injury occur	red		
Division	or Atteny after deat Director: I in by the	ertification:	2 Accident invastigation 3 Suicida 6 Could not be determined 28a. Placa of Injury - At homa, farm, streat, factory, offica bullding, atc. (Specify)					J Tas 2∐No	28f. Location (Street and Number or Rural Routa Number, City or Town, State)				
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1/	diffice of the party of the par	Me	29b. Signature and titla of certifiar	marrial addo		2	9c. Licen	se number		29d. Data signe	d (Month, i	Day, Year)	
Ü	8%		Madul 44	La MI)			7)4	6246		Tilu	30	100	79
	COS O		30. Nama and addrass of person who co	mpleted causa of daa					1. A 2	July	50	(17	1 1
	- C40	to	31. Data filed (Month, Day, Year)	32. Registrar's		WH	LUC	DEF 1	41) 1	0003			
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State of Maryland / Department of Health and Mental Hygiene 9 9

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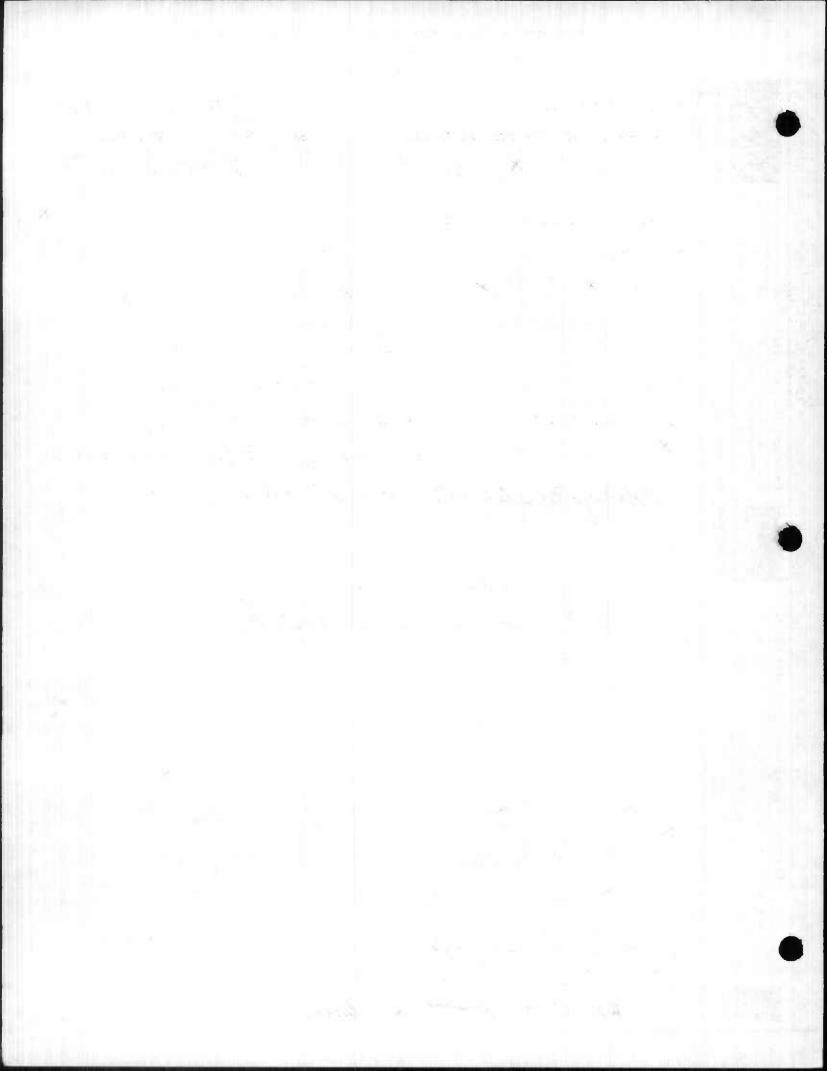
					Ce	ertificate o	f Death	F	Reg. No.	
			1. Decedent'a Neme (First, Middle, La	st)				2. Dete of Dea	ith	3. Time of Death
	Physic		Nettie S.	Carver				July 2	25,1999 Yea	11:20 PM
	/Medi Exami		4a. Fecility Name (If not institution, giv				4b. City, Town, or			
1			15005 Health	Care Center			Bowie		Prince	George's
	Funeral	Г	5. Sociel Security Number 6. S	ex 7. Age (In	yrs. last birthday	If Under 1 Ye	ar if Under 24 Hrs	8. Date of Birth	0.8	irthplace (State or Foreign Country)
A)	Director		578 05 0072	□M * F 9	7 Yrs.	Months Day	ys Hours Min.	NOV 10,	1901 Ma	ryland
	p.		Usuel Residence of Decedent							
	anyter	_	10e. State 10b. County	100	. City, Town or L	_ocation				10d. inside City Limits
	Sa-f	cto	MD P.G.		Bowie					1 ☐ Yes 2√ No
	ith th	Director	10e. Street and Number			10f. Zip Code	Э	1	10g. Citizen of Whet (Country?
	ath w	Ta .	15005 Health C				716		United Sta	
	or de	Funeral	11. Marital Staius	12. Was Decedeni Ever Armed Forces?	in U,S. 13.	 Was Decedent of if Yes, spacify C 	if Hispanic Origin? (S uben, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Rece - An Bleck, Wh	nerican Indien, lite, elc.
20	d within 72 hours efter death with the Marylend jiene. Than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by F	1 Never Married 2 Merried	1 ☐ Yes 2 ☑ Yo If Yes, Give		1 ☐ Yes 2 📆 🕱	to Specify:		Specify:	
00	ural'	D	3 Widowed 4 □ Divorced	Yeer or Dates:		214				hite
21215-0020	n 72	Completed	15. Decedent's Ed (Specify only highest gre	de completed)	(Giv	edent's Usuel Occ le kind of work dor DO NOT use ret	ne during most of wo	rking	16b. Kind of Busines	s/Industry
12	should be filed withind Mental Hygiene. merked other than matic event, the M	E G	Elementery/Secondery (0-12)	College (1-4or 5+)				- 3	D G G.	
	ould be filed with Mental Hygiene. arked other than atic event, the M		8th 17. Fether's Neme (First, Middle, Last)		Ste	nographe			D.C. Chan Meiden Sumeme)	ber of Comme
Maryland	d be od o	Be	Samuel Brookban				Ruth K			
2	should and Men marke umatic	5	19e. Informent's Name/Relationship (10h Mail	ling Addrose (Ctre			r, City or Town, State	Zin Codel
Ma	2000		Barbara T. Shiel							
é	1 and Health em 27		20a. Method of Disposition		b. Plece of Disp	position (Neme of		Date	lville, N	
0	nt of nt of nt of nt of or or or		1 Burial 2 ☐ Cremetion 3 ☐	Removal from State	cemetery, cre	emetory or other p				od, Maryland
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr once.		4 Donation 5 Other (Specif	1					Home, Inc	
Ba	Depa Impo any Ir		21. Signature of Funeral Service Licer	//						land 20735
	101,0		MUXIMA	ah						7 Lana 20755
			23e. Part1. Enier the diseese, or com shock, or heart failure. List only	plicetions thei caused the one cause on each line.	deeth. Do not er	nter the mode of o	tying, such as cardle	c or respiratory are	rest,	Approximete intervei Between
	Physician							- 1		Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	· (01)	72510	e 17	euls	Fail-	1	Monshs.
60		<u>.</u>	resulting in death)	Die	to (or as a conse	equenca of):)		
_	ed sit	ine		b						
_	the death certificete be executed y the attending physician end tched for use as the bunal-transit	Examiner	Sequentially list conditions, if env. leading to immediate	Due	to (or es e conse	equenca of):				
09	be e ician buria		if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury	C						
68760,	sath certificete be exattending physician for use as the buna	Medical	that initiated events resulting in death) Lest	Due	o (or es a conse	equence of):				
×	ding ding	3		d						
Bo	attend for us	Physician/								
o.	thet the de ad by the detached	ysi	Part ii. Other algnificant conditions o	oniributing to death but not	resulting in the	underlying cause	given In Part i.			te to the cause of death?
<u>α</u>								1 U Y	/es 2□No 3□	Probably 4 1 Onknow
Records,	requires thet been signed to hould be deta	d by						246 Mag	on outcook 24h	. Were autopsy findings
0	requir been s should	ete						24e. Was e perfor	med?	eveileble prior to completion of cause
3ec	80 W	Completed								of death?
	Pa age	Col						1□ Y	es 2 No	1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11				ath (Check only or	ne)	
of	Physic this c	10	1 Yes 2 UNO		2 ☐ ER/Outpatie	eni 3LI DOA			lence 8 Other (Sp	pecify)
	ng P	on:	27. Menner of Death 1 □ Waturei 5 □ Pending	28a. Date of injury (Month, Day Yea	28b. Time injury	V		28d. Describe h	low injury occurred	
Sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be				☐Yes 2☐No			
Division	after d Direct	Certification:	4 Homicide determined	28e. Place of injury - a building, etc. (Sp	At home, ferm, s rec <i>ify)</i>	treet, factory, offic	ca	28f. Location (S City or Tow	Street end Number or m, Stete)	Rurel Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer									
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Eather	ricium. To the best of my	knowledge, dea ninetion and/or in	th occurred at the nvestigation, in m	time, date and place y opinion, death occu	e, end due to tha c arred et the time, c	ceuse(s) and menner date end piece, end d	as stated. ue to the cause(s)
	the the	Med	one)	and menner stated.		one ties		Τ,	and Data signed (14s	ath Care Vacal
	5 × 5 9		29b. Signature and tale of carries	-m N		Zac. Lice	ING 70) '	29d. Dete signed (Mo	6-96
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134			30. Name and eddress of person who	impleted cause of deeth	(Item 23e) (Type	, Print	LA -1)	1/ 11/	20705
10)		1V90W	JOWAK	un	100	v, 4	here	1 141.7	2 10)
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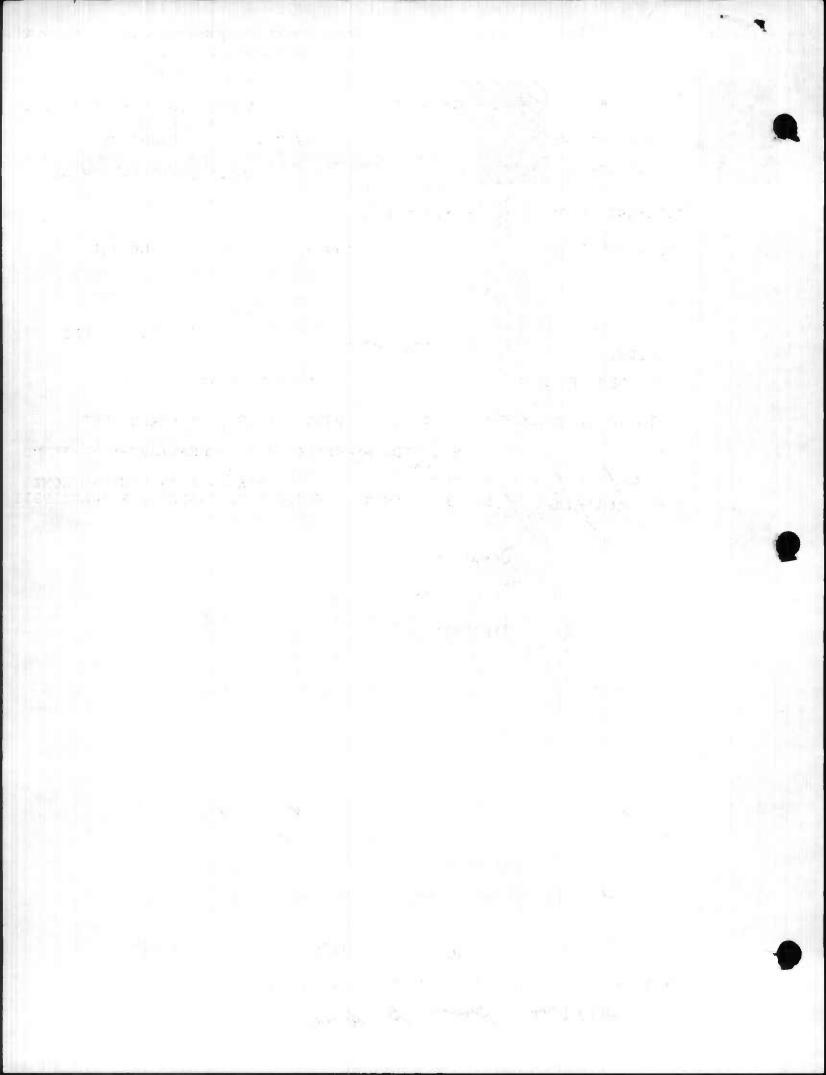
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** Month Helen Cook Mary 1624 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 1 Min. | 1 Min. | 1 Min. | 24 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 Min. | 3 PENINSULA REGIONAL MEDICAL CENTER WICOMICO 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** Year) 4 1941 1 M 2 F 216-38-8246 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 Waciona Drive 21801 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Itam 27 Is marked other then *i any figury or other traumatic event, the Means. Elementary/Secondary (0-12) College (1-4or 5+) Domestic None Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be John Brown SR. 2 Helen Leatherbury 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 713 Rose Street Salisbury, Md. 21801 Aaron Cook (Son) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Princess Anne, Md. Polks Rd.Cemetery 22. Name and Address of Facility
Stewart Funeral Home 21. Signeture of Funeral Service Licansee B. 821 West Rd.Salisbury, Md. 21801 23a. Part1. Enter the diserte, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heed failure. List only one ceuse on each line. Approximate interval Betw Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death cartificate be axecuted attending physician and for use as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Lest Box 68760, Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? page 2 cartificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this cartifica stalf filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Annatient 2 EP/Outpatient 3 DOA 2 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Store Dr Salisburg mo 2180 Chapter J. Roab mo 400 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State 1999 **AUG 11** Registrar

DHMH 16 Rev 6/95



··-		Amend #26 WCHD 8	/11/99 cle		Certificate of		F	eg. No.	26827
Physic /Medi		1. Decedent's Nama (First, Middle, La LEANORA		CHANC	EY		2. Data of Dea Month AUGUST	Day 19	3. Time of Death 99 6:10A.M.
Exami		4a. Facility Name (If not institution, give				4b. City, Town, or		4c. County	
Funeral Director		218-34-7516	Sex 7. Age (I	n yrs. last birti 86 Y	hday) If Under 1 Yaar Months Days	DENTON If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day	CARO	UINE 9. Birthplace (State or Foraign Country) N. VIRGINIA
with the Maryland a or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County DELAWAR E SUSS		SEAF					10d. Inside City Limits 1 ☐ Yes 🌠 No
death with the Maryland ms 23a or 28a-f show rmust be notified at	al Director	10e. Street and Number RT 2 BOX 3291)	-	10f. Zip Code 199	73		Og. Citizan of V	/het Country? ERICA
_ <u>5</u> 2 2	by Funeral	11. Marital Status 1 Nevar Married 2 Married **Widowed 4 Divorced	12. Was Decedent Eventh Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:	er In U,S.	13. Was Decedent of H If Yas, specify Cubi 1 ☐ Yes 2 ☐ No	Ilspanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, atc.)		- American Indian, k, Whita, atc. WHITE
Vithin liene.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12YRS •	ducation ade complated) College (1-4or 5+)		Decedent's Usual Occup (Give kind of work done lifa. DO NOT use retired IGADIER	pation during most of wor d)	king	16b. Kind of Bu	sinass/Industry ION ARMY
aryland 2 should be filed and Mental Hygi- merked other	To Be C	17. Father's Name (First, Middle, Last	GIN			18. Mother's Nar BESSIE	ne (First, Middle, ATHE)		
C = N L		19a. Informant's Name/Relationship (PHYLLIS J. CO	ULBOURNE	RT					
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	WICOM	Disposition (Name of crematory or other nia: ICO MEMOR	TAL 8	Date /13/99		City or Town, State URY, MARYLAND
Baltimo		21. Signature of Fundal Service Lies	nsee Vate		RK 22. Name and Addra FRONT &				UNERAL HOME DELAWARE1997
Physician /Medical Examiner		236 Part 1 Emil 2 disease or con shock or hear failure List only immediate Cause (Fival disease or condition resulting in death)			ot enter the mode of dylr	ng, such as cardiad	or raspiratory arr	est,	Approximate finterval Between Onsat and Death
Box 68760, eath certificate be axecuted attending physicien and for use as the bunk-leaned	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Dens Hypoil	AYPOIC	onsequence of):				
O. B.	Physician/M	Part II. Other significant conditions of	ontributing to death but n	ot rasulting in	the underlying cause giv	ven in Part I.	23b. Did to	bacco uae cor	tributa to the cause of death?
IS, P.O. B es thet the dear igned by the atta be detached for	by Phy						1 🗆 Y	es 2□ No	3 Probably 4 Unknown
aw requir	Completed b		(24a. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?
Vital Rician: The Licentificate he rector, page		05 146						es 2 No	1 ☐ Yes 2 ☐ No
of Vita Physician: this certific	To Be	25. Was case referred to medical axaminer? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Out	patient 3 DOA Oth		ome Trust		or (Specify)
Vision or Attending Phoracon or death.	Certification:	27. Manner of Death 14 Natural 5 Panding 2 Accident investigatio 3 Sulcide 6 Could not be	0 00 00 00		jury Wor M 1□		28d. Describe h	ow Injury occurr	
Divisi To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicida determined	building, atc. (Saystclan: To the best of m	Spacify)	m, street, factory, offica	mo data and places	City or Tow	n, State)	
he Hos in 24 h he Fun pletely	edical	(Check only 2 Medical Examone)	ninar: On the basis of example and manner stated	amination and	or Invastigation, In my o	ppinlon, daath occu	rred at the time, d	ate and place, a	and due to the cause(s)
To t To th	Σ	29b. Signature and title of certifiar			29c. Licens				(Month, Day, Year)
		30. Name and addrass of person who	~	(f)		0011537	2	8/10/0	19
3		Jorge Abrego	MD fo	Box 6	60 Den	ton mo	21629		
Sta Registr		31. Date filed (Month, Day, Year) AUG 11	32. Registrar's	Signature	& Som	1/2/			



State of Maryland / Department of Health and Mental Hygiene 🔍

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician DUGAS, JR AUGUST

4b. City, Town, or Location of Death JOHN 10 1999 /Medical 03:02AM 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Jul 30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1932 15 M 2□ F 67 Yrs Director 372-30-1340 Michigan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow 1 ☐ Yas 2 ☑ No Severna Park Director MD Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Baltimore Annapolis Blvd. Harra 23a 21146 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United States Air Force Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental John Dugas, Sr. Marie Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Baltimore Annapolis Blvd. Severna Park
of Disposition (Name of Date 200: Location - City of Town, State 46 Joan Dugas / Wife Date 1 1 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Aug 1 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department important: If any injury or Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fameral Service Lioutity Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 and father the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death **Physician** /Medical METAROLIC ACIDOSIS Immediate Causa (Final PROFOUND diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner SERSIS Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical Due to (or es a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No CANCER 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ours after deau.

Vi Director: An.

Vin by the fur-5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medicai 29a. Certifier completaly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) landa RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOLANDA ZICKMANN JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET BALTIMORE, MD 2128 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 1 6 1999

2 - march . 888 3 1 842

1999

WORCESTER

Race - Amarican Indian, Black, White, etc.

Specify: AFRO-AMERICAN

4c. County of Death

3. Time of Death

6:30 pm

Birthplaca (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

2. Dete of Deeth

4

USA

August MARGIE MAE DIXON /Medical 4a Facility Nama (If not Institution, give street end number) 4b. City. Town, or Location of Deeth **Examiner** BERLIN NURSING AND REHABITATION CENTER BERLIN 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 20XF Director 217-30-7883 Usual Rasidence of Decedent MAY 10, 1918 snowHILL, MD. 10a. State 10b. County 10c. City, Town or Location MD. WORCESTER SNOWHILL Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 7049 SHOCKLEY ROAD. 21863 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 💢 No If Yes, Give Maryland 21215-0020 8 1 Yas 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 8th DOMESTIC HOUSEKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Margie Dixon Mertal TEAMER DIXON, SR. MARTHA TAYLOR 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8905 IRONSHIRE ROAD, (STATION), BERLIN, MD. 21811 Important: If item 27 any injury or other tr LEWIS DIXON altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cematery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JAMES AME CHURCH CEM. 8-12 SNOWHILL, MD. 21. Signeture of Funaral Service Licenses 22. Name end Address of Fecility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801 23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilura. List only one cause on each line. **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner 10. many The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequenca of) P.O. Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 certificate of Vital or Attending Physician: 25. Was case referred to medicat examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division After 5 Pending s after death. 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piaca, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) within 2 \$ 29b. Signatura and the of certifier 29c. License number 29d. Dala signed (Month, Dey, Year)

Approximete Interval Between Onsat and Death Ry bise ase 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings available prior to 24a. Wes an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

August 6, 1999

State Registrar

31. Date filed (Month, Dey, Year) AUG 1 1 1999

1. Decedent's Name (First, Middle, Last)

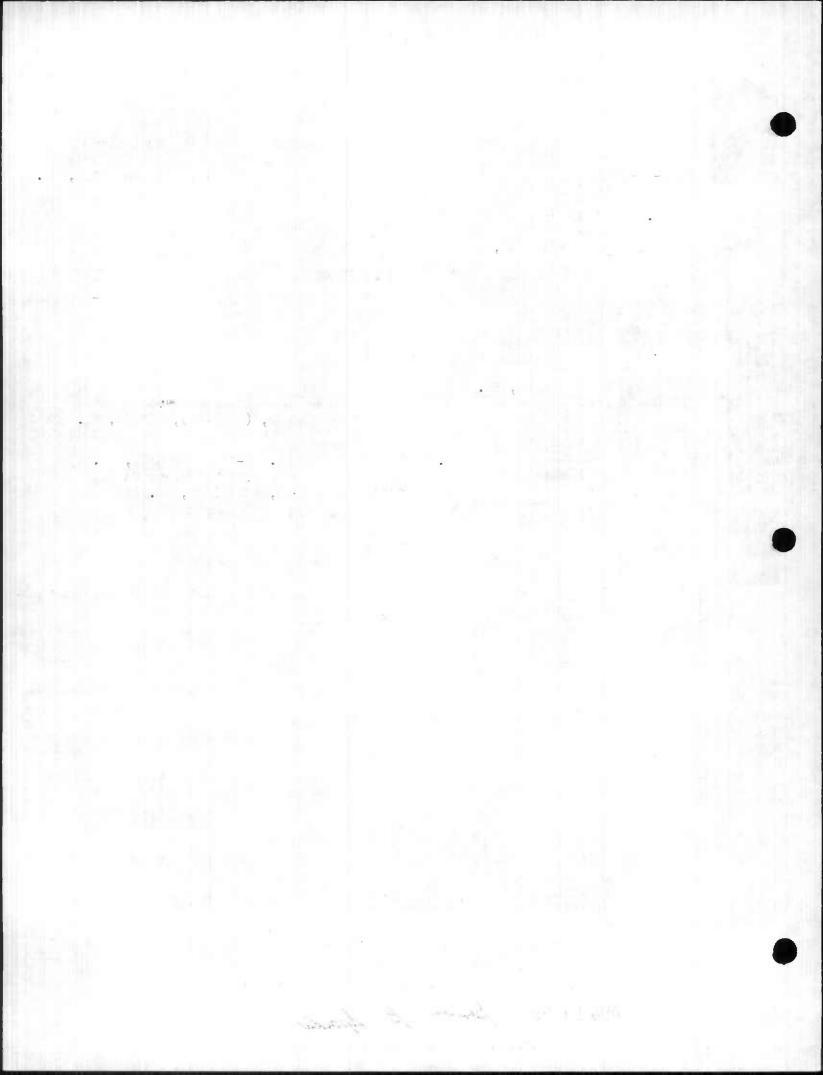
Physician

Federcio G. Arthes, M.D., 46 Teal Circle, Berlin, MD 21811 32. Registrar's Signeture

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

Sparker

D02026



State of Maryland / Department of Health and Mental Hygiene 9 26830

sician edical	1. Decedent	s Name (First, Middl															
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ıminer	4a Facility N	eme (If not institution	n, give st	treet end n	umber)					4b. City, To	wn, or Lo	cation of Deel	h 4	c. County	of Death		
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eral	5. Social Sec	urity Number	6. Sex		7. Age	(In yrs. last	birthday)		r 1 Year			8. Dete of Bi (Month, Di	th You	-1	9. Birthp	lace (Sta	te or Foreign
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Registrar

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Virginia Grant D							-	8, 198	19	1:5	50 A.M.
4a. Facility Nama (If not institution, give 11450 Asbury Cir		419				city, Town, or L	ocation of Death	4c. Cour Calv	ity of Deetl ert	h	
5. Sociel Security Number 015–20–0765 6. Se	x 7. Aga □ M 2XF 76	(In yrs. last birt		Undar 1 Yo onths Da		f Undar 24 Hrs. Hours Min.	8. Data of Birt Month, Ba	, Year 922	9. Birth South	nplace (S LTP) Ca	tete or Foreign crolina
Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town		on							de City Limits
Maryland Calvert		Solomo	ns							1 🗆	Yas 2 No
10e. Street and Number 11450 Asbury Cir	cle Apt. #	419		10f. Zlp Cod 20 688				10g. Citizen o United			
11. Meritei Stetus	12. Wes Decedant Ev	var in U,S.	13. Wes	Decedent	of Hisp	anic Origin? (Sp	pecify Yes or No		ece - Amai		an,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yas 2 No If Yes, Give Yeer or Detes:			Yes 2	1	Mexican, Puarto Specify:	o Hican, a(c.)		eck, White		
15. Decedent's Ed	ucation	16a.	Decedent	's Usuel Oc	ccupatio	on		16b. Kind of	Business/I	ndustry	
(Specify only highest grad	2 ^{Collega (1-4or 5+})				Assist		Educat	ion	/ Uni	iversity
17. Father's Neme (First, Middle, Last)					18	3. Mother's Nem	ne (First, Middle,	Melden Sumi	ame)		
Gordon Grant	Drivet	401-	A 4 - 215 A	44		Jesse G			0		
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4 □ Donation 5 □ Other (Specify,		Lee Cr	remat	orv	Aug	. 9, 19	99	Clinto	on. Ma	arvla	and
21. Signeture of Funeral Service Licente	100		22. Na	ame end Ad	ddrass	of Facility L	ee Funer	ral Hon	ne, Ca	alvei	ct, P.A
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cause, Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	c	ue to (or es a co	onsequen	ce of):							
Pert II. Other significant conditions co	ntributing to death but	not resulting In	the under	tying cause	e given	in Pert I.	23b. Did t				use of death?
							perlo	an eutopsy med?	0	vallable pompletion of death?	n of causa
OF 101							101	- 1	t	☐ Yea	2 No
25. Was case referred to medical examiner?	Hospitel:				Other:		th (Check only o				
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4 Homicide determined	28e. Plece of Injury building, etc.	y - At nome, fer (Specify)	m, street,	rectory, offi	ICO		28f. Location (S City or Tox		noer of Hu	rai Pioula	rvumber,
29e. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	elclan: To the best of ner: On the basis of a end menner stete	xamination end	deeth occivor investi	curred et the	e time, ny opini	dete end plece, on, deeth occur	end due to the cred at the time,	cause(s) end r date and plece	manner as a, and due	stated. to the ca	use(s)
29b. Signetura and title of certifier G.	Sike	. (4)	1	29c. Lic	ense ni	463		29d. Data sign	ed (Month	Day, Ye	er)
30. Name and address of person who o	ompleted cause of dea	th (Item 23e) (Type, Prin	t)						•	
Bruce A. Silver					uite	110, F	rince F	rederio	ck, M	D 20	678

ID

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the luneral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Director

Be Completed by Funeral

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other treumatic event, the Medical Exercities must be notified at

Physician /Medical

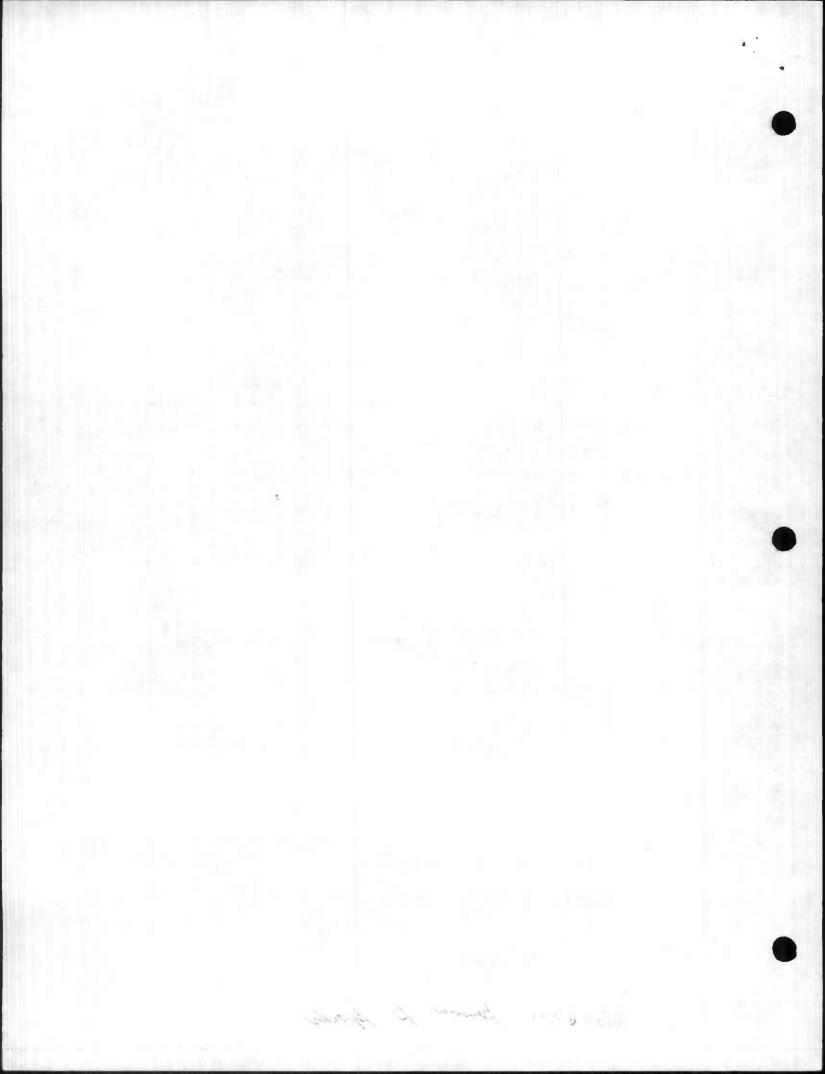
Examiner

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year) AUG 0 9 1999



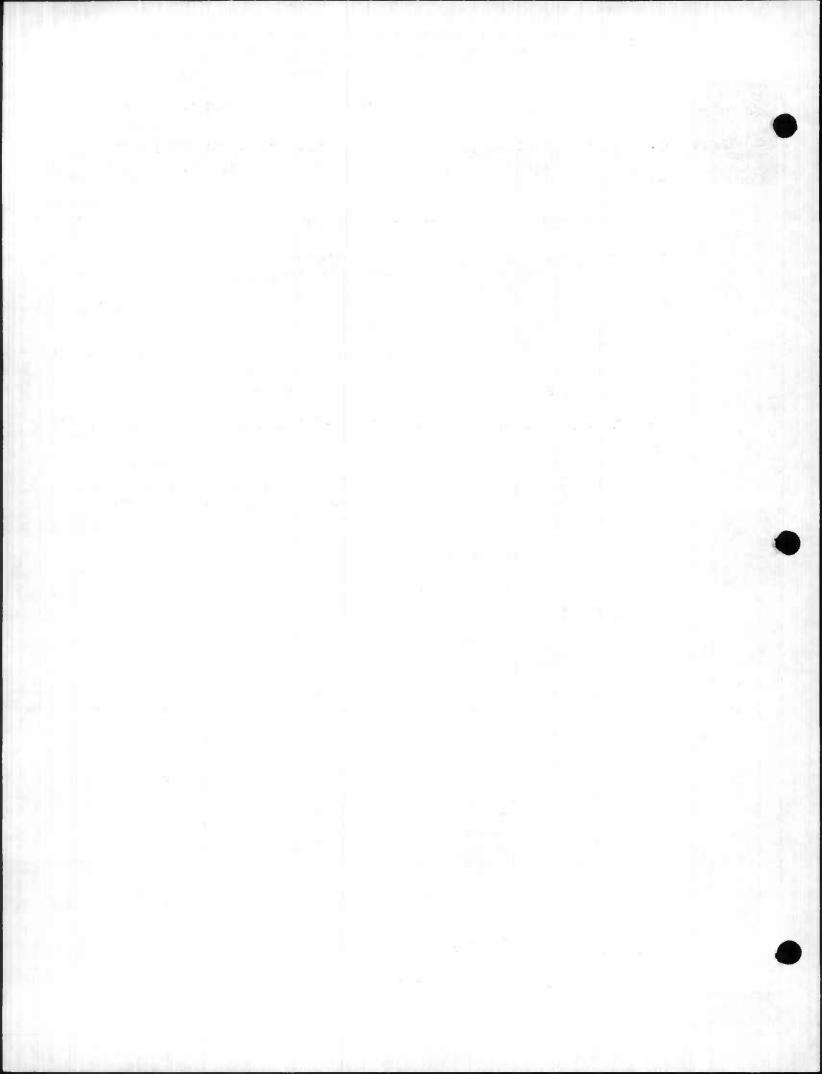
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	/Medical Examiner	4s Facility Name (If r	oot institution, give			Ī	4b. City, Town, or L				J.40 AM
	Funeral Director	5. Social Security Nur 218–16–75	6. So	Genesis I	(In yrs. last birthd	(ay) If Under 1 Year Months Days		8. Data of Bi (Month, De	Wicomi ey, Year) r 5,1923	9. Birthpli Count	aca (State or Foreign ry) cyland
	P P	Usual Residence of D	ecedent 10b. County		10c. City, Town or	r Location				10	d. Inside City Limits
	4 sho	Maryland	Wicomic		Salis						1 ∑ Yas 2 □ No
	or 28e-f	10e. Street and Numb	per			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	N with	200 Civi	c Ave.			2180	4		USA		
020	72 hours effect deeth with the Meryland natural", or frame 23e or 28e-f show deel Essen has mark be notified as sted by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates:		3. Was Decedent of if Yas, apecify Cut 1 ☐ Yes 2 ☒ No	oan, Mexican, Puarto	ecify Yes or No Rican, etc.)		a - America k, Whita, a : Wh:	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours et Depertment of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or any Injury or other treumatic event, the Medical Essentials. To Be Completed by F	(Specify Elementary/Second	5. Decedent'a Ed only highest grad lary (0-12)		(G lif	ocedent's Usual Occu ive kind of work done e. DO NOT use retin omemaker	pation during most of work ed)	sing	16b. Kind of Bu		ustry
	Hygin of the Co	17. Father's Nama (Fi	irst, Middla, Last)	-	110	AIRCHAICE	18. Mothar's Nem	e (First, Middle	, <i>Maiden S</i> umam	a)	
rian	Mentel Farked original Person artic even	Otto Huds	on Short				Grace I	Meta Tr	uitt		
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	Health em 27 other tr	Rev. Howsa	ird E. Ev	ans/Husbar		1, Box 4	59A, Delm				
aitimore,	Pages Inent of It int: If ite inty or ot	20a. Method of Dispo- 1 ☑ Burial 2 ☐		Removal from State	cematary,	sposition (Nema of crematory or other pla	0	Data 1/7/99	Laurel		m, Stata
H	Deperment Peperment Important: If any Injury o	4 ☐ Donation 5 21. Signature of Fune			Odd Fel	lows Cemet	SET A	7 1 7 3 3	Laurer	, DE	
Ba	Departi Departi Importa eny inje	1 Davi	29A. H	damoone 1	101051	Holloway 501 Snow	Funeral H Hill Rd	Salisb	urv. MD		
		23a. Part1. Enter the shock, or heart l	disease, or compleilura. List only of	plications that caused to ona cause on each line	ha death. Do not	entar tha moda of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
P	Physician /Medical Examiner	Immediata Cause (Fi disease or condition resulting in death)	nal	· ATTEN	-Scoro	two CA	201048	alve	Disens		
		resouring wir deathy			Due to (or as a con	esequence of):					13018=3
0,	physician and the buriel-transit dical Examiner	Sequentially list cond if any, leading to imm cause. Enter Under Cause (Disease or in) that initiated events	itions, ediata ring	b	due to (or as a con	sequence of):					
x 68760,	deeth certificate be executed the control of the co	that initiated events resulting in death) La	st	d	ue to (or as a con	sequence of):					
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P.O.	thet the detech	p, shel	es .	entributing to death but	not resulting in th	a underlying causa g	iven in Part I.		Yes 2 No		the cause of death? ebly 4 Unknown
Records,	been should	Rouse	insife	Precent				24a. Was	s an autopsy ormed?	con	ra autopsy findings illable prior to appletion of cause leath?
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VItai	certificate rector, per	25. Was case refarred examiner?	d to medical	0			26. Place of Dee	th (Check only	one)		
of V	7 00 5	1□ Yes 2□ No		Hospital: 1 ☐ Inpatien		tient 3LI DOA			idence 8 □Oth)
	Affects funeral funera	27. Manner of Death 1 2 Natural	5 Pending	28a. Data of Injury (Month, Day	Year) 28b. Tim	ry Wo		28d. Describe	how injury occur	red	
Division	her desti lirector: in by the	2 Accident 3 Suicide 4 Homicide	invastigation 6 Could not be determined		y - At home, larm, (Specify)	M 15	Yas 2 No		(Street and Numb wn, Stata)	er or Rural	Routa Number,
	Hospi 24 hour Funer stely fill dical	ane)	Certifying Phy Medical Exam	reicien: To the best of iner: On the basis of a and manner state	xamination and/o	eath occurred at tha t r invastigetion, in my	ima, data and place, opinion, death occur	and dua to tha red at tha time	cause(s) and ma , data end place,	innar as sta and due to	ated. the cause(s)
	To To To To To To To To To To To To To T	29b. Signature and titl	le of certifier			29c. Licen	se number		29d. Data signed	d (Month, E	Day, Year)
	My Voyage	1 6	Miles	2		10	39813		8/4	190	7
	0	30. Name and address	s of person who o	completed cause of dec	ath (Item 23a) (Ty	pe, Print)	e, 8	inles	mo z	180	7
	State Registrar	31. Data filed (Month,	Day, Year) JG 0 6 19	32. Registrar	's Signature	5 Spar	h				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryl		ertificate of			giene	9 2	6833
	Dhusia	ian	1. Decedent's Neme (First, Middle, Last	1)				2. Date of De	eth	Veer	3. Time of Death
	Physic /Medi		ALBERT Ar	mas	ENG	LUND		AUGU	ST 3,19	999	20:10
	Exami	ner	4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or L	ocation of Deet			
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	pud *		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or	Location					
	Aaryle	5	,							119	0d. Inside City Limits 1 ✓ Yes 2 ☐ No
	the the	Director	MD Calvert 10e. Street and Number		Prince	e Freder	1CK		10g. Citizan of W	What Cours	27
	3a or		470 W. Dares B	onah Dond	4412		670				uyr
	death 2	Funeral	11. Maritel Stetus	12. Wes Decedent Ever in		B. Wes Decedent of I If Yes, specify Cub	678 dispenic Origin? (Sp	pecify Yes or No	USA - 14. Reca	a - Amarica	an Indien,
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mantai hygiana. I health and Mantai hygiana. Item 27 is marked other than "naturel", or items 23s or 28=f show other trsumstic event, the Medical Example must be notified as	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		If Yes, specify Cub 1 ☐ Yes ¾☐ No	en, Mexican, Puerto Specify:	Rican, etc.)	Specify.	k, White, d	
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and	ntai h	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Nem			e)	
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	/Medical Examiner bhysician and stranging the burlat-transit	il Examiner	Immedieta Causa (Final disease or condition resulting in deeth) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	colon	Failure o (or as a cons Concer o (or es e conse	equence of):					
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0	0 0 0	sicla	Part II. Other significant conditions cor	ntributing to death but not	resulting in tha	undarlying cause giv	en in Part I.	23b. Did	tobacco usa con	tributs to	the cause of death?
S, P.O	es that the day igned by the e be detached f	by Phy						1 🗆	Yss 2⊠No	3 ☐ Prob	ably 4 Unknown
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			Dan 1.	Tandro MK	7	04	7610		Rugust L	1 19	799
5			30. Name and eddrass of person who co			Print)					
		10	Dr. David Tare 31. Dete filed (Month, Day, Year)	dio, M.D. 32. Registrer's Sig		nce Fred	erick, N	MD 206	78		
	Sta Registr	-	AUG 0 5 199			low	1/2/2				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month **Physician** 22 Stephanie Dawn Eades May 1999 9:40 p.m. /Medical 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, 9. Birthplece (State or Foreign Country)
W. Va. **Funeral** 1□ M 20 F Months Days Hours 235 15 4705 20 W. Director June 10, Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Wallical Examiner mast be notified at 1⊠Yes 2□No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1380 Marshall St. 21740 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Nea any injury or other treumetic event, an Wedical Exactions 12 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) handicapped none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger C. Haynes Linda F. Haynes 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 107 Manda Dr. Linda F. Haynes Mother Middletown Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State Reformed Cemetery 5/25/99 Middletown, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²²Donald B. Thompson Funeral Home Middletown, MD. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Records. P.O. Box 68760, Physician/Medical signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 10 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to should 24a. Was an autopsy performed? Completed completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital Attending Physician: funeral director, 25. Was case referred to medical 26. Plece of Deeth (Check only one) examipé 1 Dres Other: 4 Nursing Home 5 Residence 8 Other (Specify) /2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA this of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 5 Pending deeth. To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director: All completaly filled in by the fu 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) uccan

State Registrar

1999

DO NOT Copy until name has been corrected heen corrected A. adrice

State of Maryland / Department of Health and Mental Hygiene 9 9 9 8 9 3

			,	Certifica	ate of	Death	,	Reg. No.	20000
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Physician /Medical	HEL			F	REEI		July	27 19	
Examiner	4a Facility Name (# not institution, gh Hemitage at St	Johns	Creek			4b. City, Town, or Solomon		Calve:	
Funeral Director			(In yrs. lest I 0 2	Yrs. If Und	der 1 Year ns Deys		8. Date of Birt	Year) 1897	Birthplece (State or Fore
2	Usuel Residence of Decedent	`	40. 07. 7.						1.041
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inter death with the maintender of the maintender maintender of the mortified Funeral Director	10e. Street end Number 13325 Dowell F	Road			Zip Code 2068	8		United	States
by	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			cedent of pecify Cub	Hispanic Origin? (Spen, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
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Health e	Robert Freeland	l- son	44	059 Fi	elds				Md. 20619-
Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturally any injury or other traumatic event, the Medical page. To Be Completed	1 Buriei 2 Cremetion 3 Cremetion 5 Other (Special 21. Signeture of Funeral Service Lice	(y)	Metr	22. Neme	end Addr	ess of Fecility	Rausch	Funera	dria Virgi Dria Virgi L Home PA Ublic MD 2
MINERAL PROPERTY.	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications thet caused	the deeth. D	o not enter the m	ode of dy	ing, such es cardia	c or respiretory at	rest,	Approximete Intervel Between
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this certific ral director, To Be	1 Yes 2 No	Hospitel: 1 Inpatier	t 2 ER/	Outpatient 3□	DUA		Home 5 ☐ Resk	dence 6 □Other	(Specify)
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	30. Name and address of person who Charles Benne 31. Date filed (Month, Day, Year)	completed cause of de	eth (Item 236 845	(Type, Print)	n Ro	1. 2.	sby, M	d. 20	657

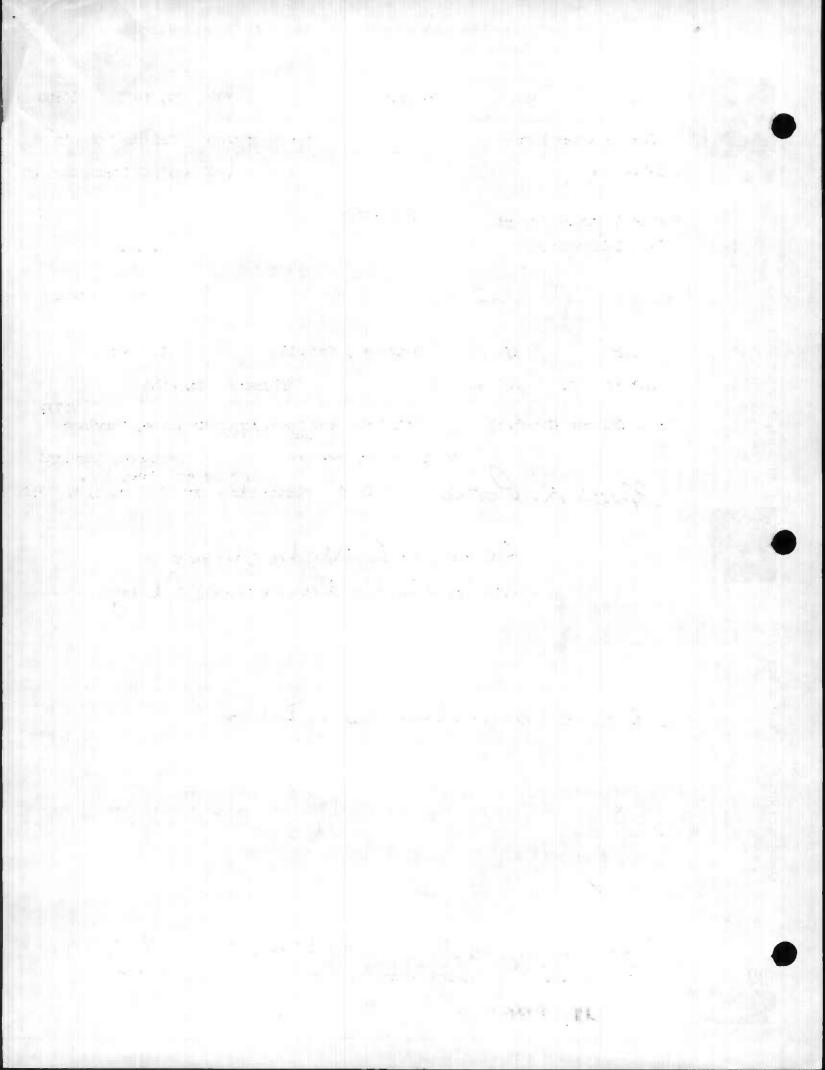
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Folliard JUIT 1999 Anna Mae 10:00 AM 27, /Medical 4e Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9226 Goldenrod Lane Upper Marlboro Prince George's If Undar 1 Yaer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys 1 M 2 XF Months Hours 70 Yrs Director 579-34-0984 April 13,1929 Washington DC Usuat Rasidance of Decedan the Maryland 10a Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yas 2 No Upper Marlboro Director Maryland Prince George's 10f. Zip Coda 10g. Citizen of What Country? 10e. Street end Number 9226 Goldenrod Lane 20772 U.S.A. Funeral death 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Ricen, atc.) Race - American Indian, Black, White, atc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Item any Injury or other traumatic event, the Medical Examination. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) 12th Computer / Payroll U.S. Navv N/A 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Andrew C. Coleman 2 Florence St. John 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 9226 Goldenrod Lane Upper Marlboro, Maryland
20b. Place of Disposition (Name of July 29, 1999) 20c. Location - City or Town, Stata comatery, crematory or other place) Frank Coleman (Brother) 20a. Method of Disposition 17 Burlat 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Nama and Addrass of Facility 21. Signeture of Funerai Service Licensee Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 5/100 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting In death) Last Box 68760, Physician/Medical Dua to (or as a consequence of): P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached the 1 Yea 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 90 24b. Wara autopsy findings evallabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed After this cartificata has 2 1 No 1 Yes 1 Yas 2 No 25. Was casa rafarrad to medical axaminar? Be 28. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Assidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 1 Matural 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? or Attending P after death.
I Director: After the funeral in by the funeral 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Coutd not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 ☐ Homictda To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifiar Medicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of certifiar 30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print) 10 3710 Rivera Street #2C Temple Hills, Maryland 20748 Mati Koul M.D. 31. Data filed (Month, Day, Yaar) 32. Ragistrar's Signatura State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Yaai 8, HARRIET BARKLEY GRANT Aug. 1999 5:00 p.m. /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death **Examiner** Neavitt
if Under 24 Hrs. 8. Deta of Birth
(Month, Day, Year)
Nov. 23, 1 6375 Thamert Rd. Talbot If Undar 1 Yaar 9. Birthplaca (State or Foreign 1906 New York 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 X Days 92 Yrs. 221-07-7467 Director Usuei Rasidance of Decedant deeth with the Meryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Talbot Neavitt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 6375 Thamert Rd. 21652 U.S.A. Items 23a Funeral 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after of Department of Health end Mentai Hygiene. Important: If Item 27 is marked other than "natural", or Ner any injury or other traumatic event. In the second of the sec Biack, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry during most of working Elementery/Secondary (0-12) Collega (1-4or 5+) 12 4 Dupont Museum 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumema) James A. Barkley Marie Pietre 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Edward A. Grant 1031 Dempster Rd. Shrub Oak, New York 10588 20a. Mathod of Disposition
1 □ Burlai 2 O'Cramation 3 □ Ramoval from State 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) Capitol Crematory Aug. 9, 1999 Dover, Delaware 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Harrison E. Leonard Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallura. List only one cause on each line. 312 S. Talbot St. St. Michaels, Maryland 21663 Approximate Interval Between Onset and Death **Physician** /Medical immediate Causa (Finat disaasa or condition rasulting in daath) Examiner Examiner bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) and ettending physician for use es the buna Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 2 No 1 Yes 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peen : completion of cause of death? has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Mospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifical letely filled in by the funeral director, 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Mannar of Death 1 Anaturat 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Pending invastigation 1 Yes 2 Accidant 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. 29e. Certifler Medical within 2 29b. Sid lura and titia of certifiar 29c. License number 29d. Data signed (Month, Pay, Year) a and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

von Klar M.D.

32. Registraris Signatura

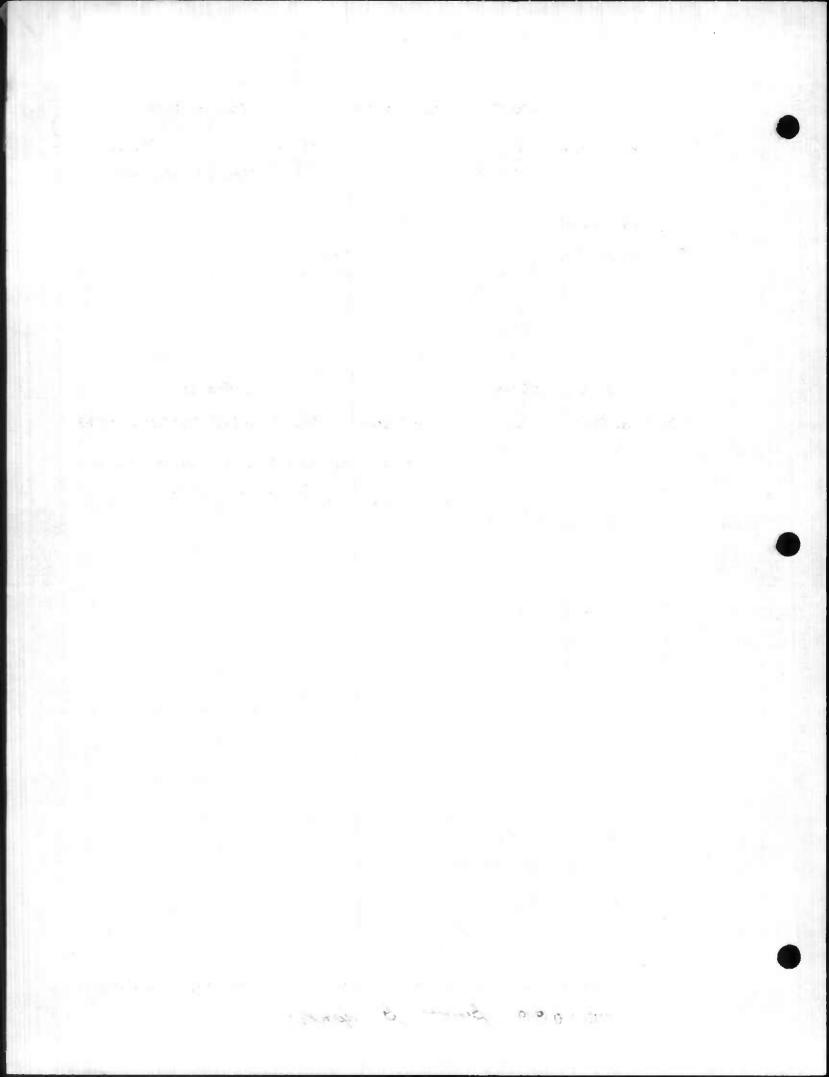
John L.

AUG 1 0 1999

31. Data filed (Month, Day, Year)

800 S. Talbot St. St. Michaels, Maryland

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 11,1999 August 2:45p.m. BETTY GERARDI /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 10 M XXF Deys Months Hours Min. Yrs. Director 441-26-4291 79 FEB. 6, 1920 OKLAHOMA Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at MD TALBOT EASTON 1 Ves 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26358 ARCADIA SHORES LANE 21601 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, etc. 1 Never Married 2X Married 1 Yas 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING FIRM 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) . Pages 1 and 2 should be filt then of Health and Mental Hight: If Item 27 is marked oth jury or other traumatic even EVERETT R. WILES MAUDE A. KEMLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 26358 ARCADIA SHORES LANE, EASTON, MD 21601 VINCENT GERARDI/ HUSBAND 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages Department of Important: If it eny injury or o pncs. 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERAN CEMETERY 8-16-99 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licens 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Finat CVA diseasa or condition rasulting in death) 4 mos Examine Due to (or as a consequence of): Examiner 4 mos Complication of angiogram physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): >15 yrs Atherosclerotic Vascular Disease Physician/Medical Due to (or as a consequence of) 88 080 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ⊠ Yee 2 No 3 Probably 4 Unknown Tobacco abuse g 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed HTN completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Hypercholesterolemia 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) Hospital: Other: 4⊠ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation A Poerra after death, in 24 hours after death, the Funerel Director; After the funeral in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier D42816 99 Kichl Pd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year) 1 3

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Betty Gerardi

Baltimore, Maryland 21215-0020

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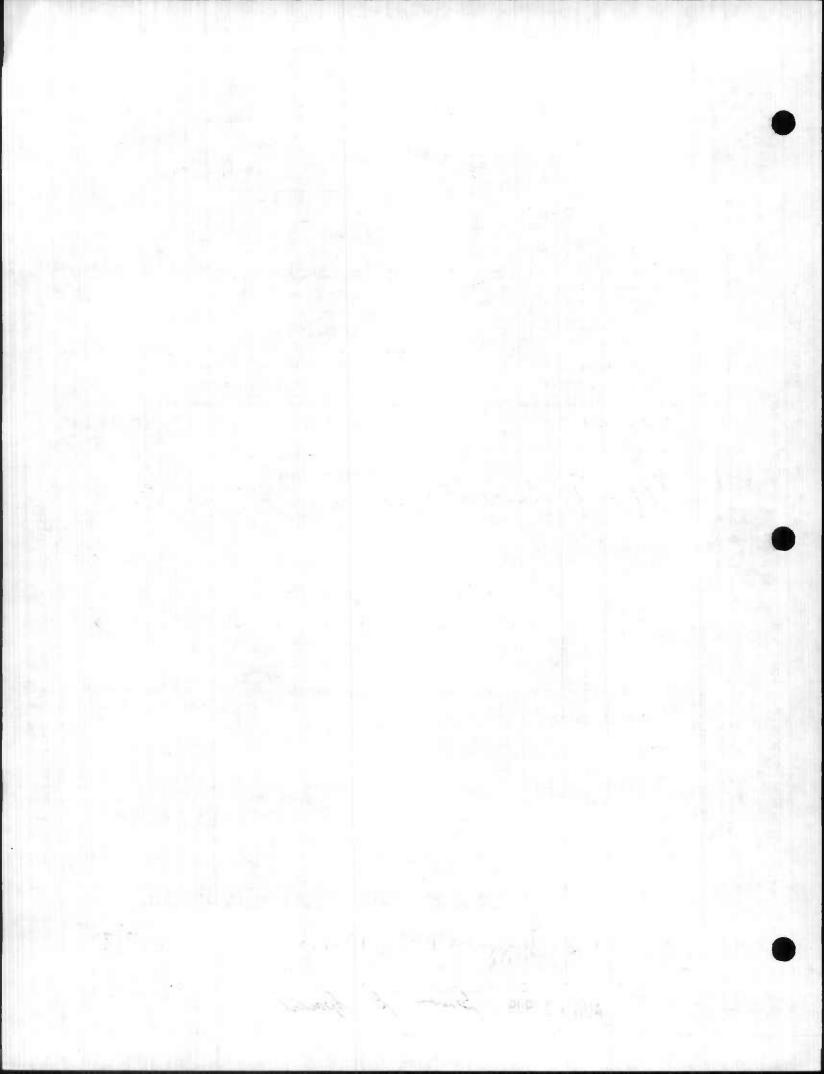
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Items 23s

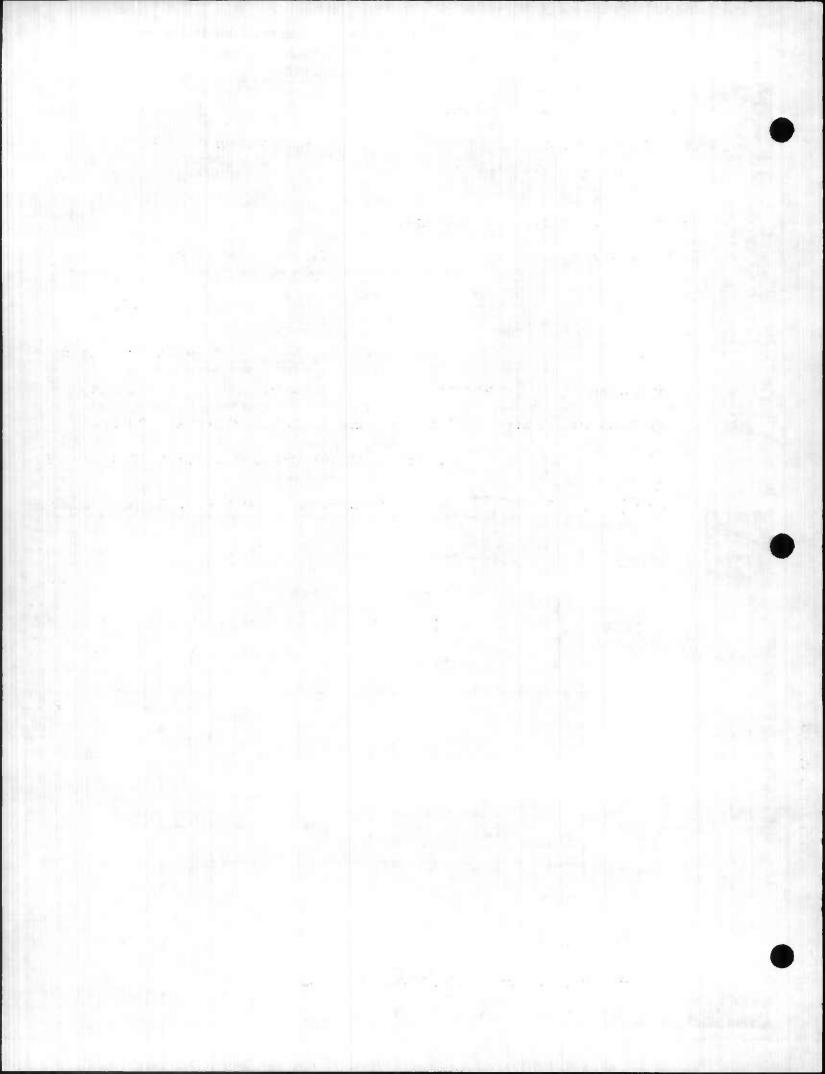
RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601
Deta filed (Month, Day, Yeer) 1 3 1999 Registral Signature

G. Sparks



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Day Month **Physician** Dorothy Florence Gary August 6, 1999 4:15 P.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1608 Arundel Road Edgewater Anne Arundel Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 383-12-8586 20, Director May 0klahoma Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show must be notified at 1 Tes X No Director 28a-f Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1608 Arundel Road 21037 USA Berns 23a Funeral 12. Wes Decedent Ever in U,S. Amped Forces? 12. Mes 2 □ No If Yes, Give Yeer or Detes 1 944-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after Hygiene. Ither then "natural", or its 1 Never Merried 2 Merried 1 Yes 2XNo Specify: Baltimore, Maryland 21215-0020 Specify à 3. Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bridal Consultant Department Store 18. Mother's Neme (First, Middle, Maiden Sumame) pemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) Be John Bailey Coats Nellie Stalev 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joy A. Lautar/ Daughter 1608 Arundel Road Edgewater, MD 21037 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3X Removel from State Poplar Springs Ch. Cem. 8-9-99 Newton, Mississippi 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Buryce Licensee 22. Name end Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Pert1. Enter the disease/or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervei Between Onset end Death **Physician** /Medical CHF Immediate Cause (Finel YRS disease or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner Wegery Alvelox physician and s the burial-transit The law requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thal initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as e consequence of) signed by the sign of dispersed f 23b. Did tobacco use contribute to the cause of death? Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 25€No 3 Probably 4 Unknown Division of Vital Records. by Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide 29e. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as eteted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) unexis, Les 21401 Mapilal 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State AUG 1 2 1999 Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Deeth Dey otzbach Stz Aug. heodore William 10, 1999 6:15AM 4e Fecility Neme (If not institution, give street end number 4c. County of Deeth Chesapeake Hospice House Linthicum If Under 24 Hrs. Anne Arundel If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Yeer) Months 10XM 2□ F Deys Hours Min. Yrs. 537-14-6638 81 June 19,1918 New York Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No No Maryland | Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21403 13 Georgetown Court United States 12. Wes Decedent Ever in U.S. Armed Forces? 1 Aves 2 No 1945 to 11 Yes, Give Yeer or Dates: 1967 Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Chief Warrant Officer W-4 12 U.S. Navy 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) William T. Glotzbach Amy Haines 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary M. Glotzbach (wife) 13 Georgetown Ct. Annapolis, Maryland 21403 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) St. Mary's Cemetery 8/13/99 Annapolis, Maryland 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funerel Service Licansee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. omonths Immediete Ceuse (Finel diseese or condition resulting In death) Due to (or as e consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) HOUSE Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

2

Funeral

Director

r than "natural", or items 23s or the Medical Examiner must be n

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

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artment of Health a ortant: If Itam 27 is

Examiner Physician/Medicai by Completed Be To

Certification:

edicai

2 Accident

3 ☐ Suicide

29e. Certifier

4 ☐ Homicide

(Check only one)

ettending physician end for use es the buriel-trans certificata has b lirector, page 2 s this funerel Affer

Box 68760. certificate be Division of Vital Records, P.O. Hospital or Attending Physician: death. after death 6 filled in 24 hours To the Hosp within 24 hou To the Fune completely fil

> State Registrar

29b. Signeture end title of certifier werny mo)

52830

1 Yes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Annapolu, mo

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

900 Jeanine Werner

Bestgate 32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year)

AUG 1 2 1999

5 Pending

investigation

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death

Reg. No.

26842

					Certifica	ate o	f Death	R	eg. No.		
		1. Decedent's Name (First, Middle,	Last)					2. Date of Dee		132.24	3. Time of Death
	sician edical	WILLIAM JO	HN GLU	CKERT,	JR.			AUGUST	11, 19	99	7:40 PM
	miner	4a Facility Name (If not institution, g	rive street end number)				4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth	
		WILLIAM HILL MA	NOR , 25 L	inn b	rook Te	rra	Ce EAST	ON	TA	LBOT	
Fune Direct		5. Social Security Number 120-18-8010		(In yrs. last		der 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Dey SEPT . 6,	Year) 1904	9. Birthplac Country NEW Y	e (Stete or Foreig ORK
pur *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City. To	own or Location					10d	Inside City Limits
e Maryle	ctor	MD TALE		100. 0.0,	EAS	TON				100.	1 Yes 2□No
th th	Sre	10e. Sfreef and Number			10f.	Zip Code		1	0g. Citizen of	Whet Country	?
th w	100	25 LYNNBROOK TE	RRACE			2	1601		US	A	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiena. If the Maryland If the 27 is marked other than "natural", or thems 23a or 28e-f show or other thaumtic avent. It wedges	by Funeral Director	11. Maritei Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent En Armed Forces? 1 Yes XXX No If Yes, Give Year or Detes:			cedenf of pecify Co	Hispanic Origin? (Suben, Mexican, Puert o Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rad Ble Specifi	e - American ck, White, etc y: WHI	
within 72 h ena. than "natu	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	completed) College (1-4or 5+	-)	life. DO NO	work doi T use ret	ne during most of wor ired)	king	16b. Kind of B		stry
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should be filed with nd Mantal Hygiena. marked other than	To Be	17. Fether's Neme (First, Middle, La WILLIAM J. GLUC	CKERT				PAULI		IK.		
1 and 2 she Health and em 27 is m		19e. Informent's Name/Relationship MARGARET M. GLU					TERRACE,				ode)
permit. Pages 1 and Department of Health Important: If item 27 any Inlury or other to		20a. Method of Disposition 1XX urial 2 Cremetion 3 4 Donation 5 Other (Spe		ceme	of Disposition (stery, cremetory of LAWN MEM	or other p		Dete 8-18-99	EASTON		
Department Department Important: In		23a. Part1. Enter the disease, or or shock, or heart failure. List or	Ostrowsk.	the death. E	FELLO 200 S	WS,	dress of Fecility HELFENBET RRISON ST lying, such es cardiac	., EASTO	N, MD 2	1601	pproximete tervel Between neet end Death
/Medic Examin	cal	Immediate Ceuse (Final diseese or condition resulting in death)	eCVA							1	4 DAYS
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icata be axecuted physician and s the burial-transit	al Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	c. HTN	Due to (or es	e consequence	or):				1 3	0 YEARS
leath certificata be axecuted in a stending physician and after use as the burial-transit	3	thet initieted events resulting in deeth) Last	D d	ue to (or es	e consequence	ot):				1	
	Physician	Part II. Other significant conditions	contributing fo death buf	not resultin	g in the underlyin	g ceuse	given in Pert I.	23b. Dld to	obacco use co	entribute to th	ne cause of death
	, .							1 U Y	es 20 No	3 Probel	oly 4 □ Unknow
has been signed as 2 should be	pleted							24e. Wes e perfor	en eutopsy med?	aveila	eutopsy findings able prior fo oletion of cause ath?
9 4 9	Con							1□ Y	es 2 No	101	res 2□ No
certificate	Be	25. Wes case referred to medical exeminer?						eth (Check only or	ne)		
Physician: this certific	2	1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER	Outpatient 3	DOA	Other: 4 Nursing H	lome 5 🖾 Resid	ence 8 Oth	ner (Specify)	
After fune		27. Manner of Death 1 Naturel 5 Pending 2 Accident Investigat		Year) 28	o. Time of Injury M		ljury et Vork? □ Yes 2 □ No	28d. Describe h	ow injury occur	rred	
	· =	3 Suicide 6 Could no determine	28e. Plece of Injur building, etc.	y - At home (Specify)	, ferm, street, fed	tory, offic	ie e	28f. Location (S City or Tow		ber or Rural F	Route Number,
o the Hospital or ithin 24 hours afte o the Funeral Dir ompletaly filled in	edicai 0	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of e	examination	ige, death occurr end/or investige	ed at fhe	time, date and place y opinion, deeth occu	, end due to the c rred et the time, c	ause(s) and m late end plece,	anner as stet	ed. ne cause(s)
o the	×	29b. Signeture and title of certifier	0			29c. Lice	ense number	2	29d. Date signe	ed (Month, Da	y, Year)

State Registrar RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601

Deterfiled (Month, Dey, Year) 1000 | 32 Agriculture Styleture (J. Appril)

30. Name end eddress of person who completed cause death (Item 23e) (Type, Print)

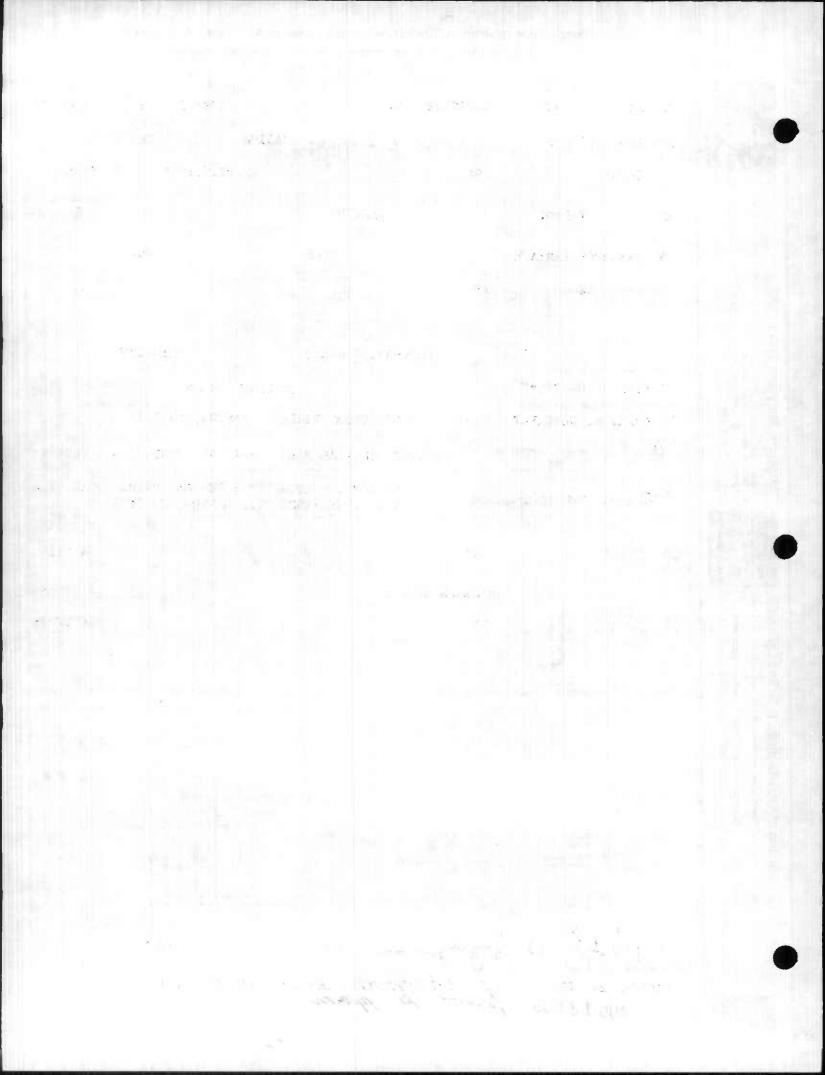
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8/12/99



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JAMES **EDWARD GROSS** 19 1999 July 11:45 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Univ. of Maryland Medical System Baltimore # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 1937 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign **Funeral** 62 Mary land 214-32-9560 Yes Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Calvert Directo Lusby 28s-f 10e Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 451 Sollers Wharf Road 20657 TISA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 b Specify: Black 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction I is marked other traumetic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) BB Pages 1 and 2 should be nent of Health and Mental Harry Gross Matilda Johnson 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Hem 27 is or other tra Lusby, MD 20657 Eva Gross/Wife 451 Sollers Wharf Road 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removat from State Ernestine Jones Cemetery 7/24/99 Chesapeake Beach, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funerel Service Licensee sevell 2 G. 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Stroke disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Atrial Fibrillation The law requires that the death certificate be asscuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. ypertension Physician/Medical Due to (or as a consequence of) US0 25 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4℃ Unknown should be det None Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitef: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2√ No 2 ER/Outpatient 3 DOA this 27. Manner of Death funeral 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

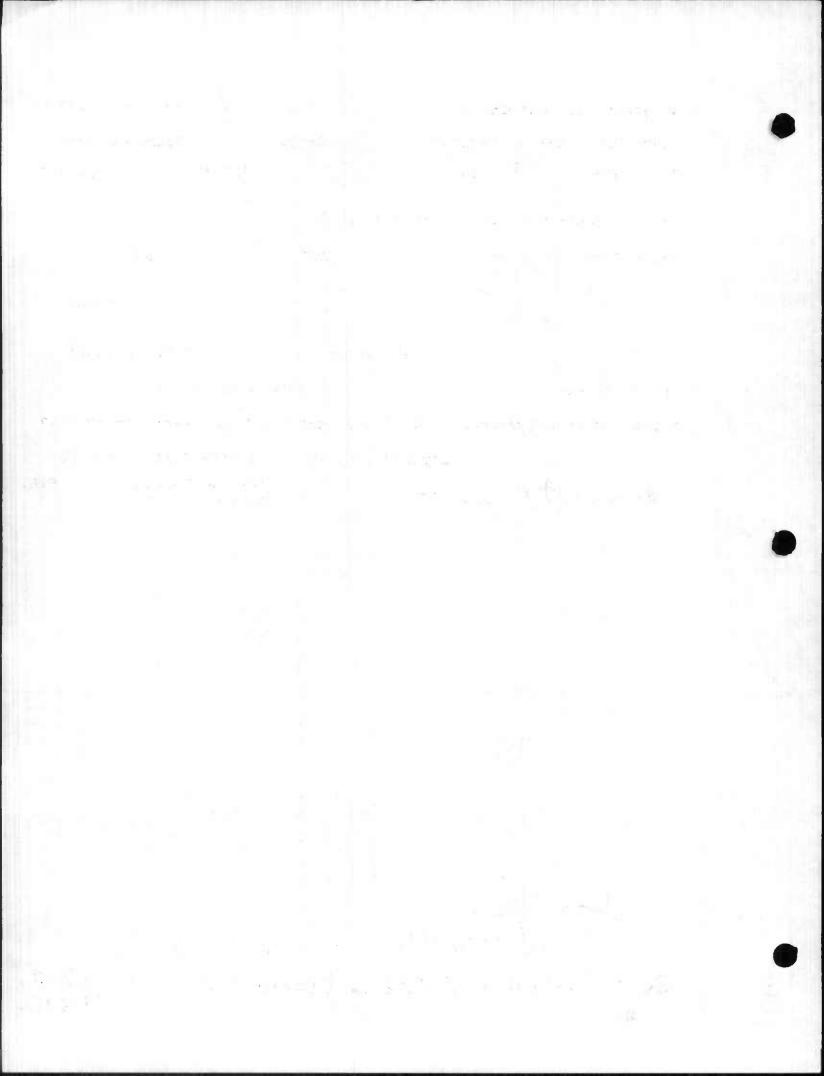
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier completely (Check only one) within 2 To the \$ 29d, Date signed (Month, Day, Year) 29b. Signeture and strip of certifier 29c. License number 20, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen THO 31. Dete filed (Month, Day, Year)
JUL 2 2 1999 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

				(Certificate d	of Death		Reg. No.	20844
	D 1 -1-1-	1. Decedent'a Name (First, Middle, La	est)				2. Date of Dec		3. Time of Death
	Physician /Medical	Julius Gray					July	27 199	9 22:55
	Examiner	4a Facility Name (If not institution,				4b. City, Town, or	Location of Death	4c. County of De	nth
1		University of Maryla	I Medical Sy	stern		Baltimer		Battemore	City
	Funeral Director	5. Social Security Number 6. 9	Sex 7. Age (In y		Months Da		8. Data of Birth Month, Day Sept. 1	77'ear)1925 9. B	rthplace (Stata or Foreign country) laryland
	p .	Usual Residence of Decedent	Lan	0					T
	show also	10a. State 10b. County		City, Town					10d. Inside City Limits
	or 28a-f s or 28a-f s be notified Director	Maryland Calve	ert		Owing				
		10e. Street and Number 7860 So1ome	ons Island Ro	ad	10f. Zip Cod	0736		10g. Citizen of What C USA	ountry?
020	er, or he Examine by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amped Forces? 1 12 Yes 2 No 19 If Yes, Give Year or Dates: 19	43-	13. Was Decedent If Yes, apecify 0	of Hispanic Origin? (Scuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Arr Bleck, Wh Specify: B1	ite, etc.
5-0	72 hz natur disal.	15. Decedent's E (Specify only highest gr		16a. C	Decedent's Usual Oc	cupation ne during most of wo	rkina	16b. Kind of Busines	s/Industry
Maryland 21215-0020	ed within 72 ho tygiene. wer than "natura it, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use re Laborer	tired)		Navy Resea	arch Lab
P	BINES O	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
lar	Mental Mental affe ev	Joseph	Gra	У		Eleanor		Wil	l1s
ary	N Pull	19a. Informant's Name/Ralationship	Type, Print)	19b. I				or, City or Town, State,	
Σ	and 2 paith a ar tra	Florence Gray/Wife	2	78	60 Sol	omons Isla	and Road	Owings, N	1D 20736
altimore,	Pages 1 a ant of He ht: If Nem ry or othe	20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery,	Disposition (Name of crematory or other Way of th	place)	Data 7/31/99	20c. Location - City of Huntingto	
3alti	epartm reporter ny injur	21. Signature of Funeral Service Lice	nsets					neral Home	
	00249	Ilodepa.)							ck, MD 20678
	Physician /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death)	Cerebral						Intarval Between Onset and Death
Box 68760,	eath certificate be executed attending physician and for use as the burlat-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	o (or as a co	nsequence of):				
	e attendir ed for use	Part II. Other significant conditions of	contributing to death but not r	esulting In 1	the underlying ceusa	given in Part I.	23b. Did t	obacco uaa contribu	ta to the cause of death?
P.0	ulras that the death cert signed by the attendin id be detached for use d by Physician/N						10	Yea 2 No 3	Probably 4 Unknown
Records,	requirement hours							an autopsy 24b	. Wara autopsy findings available prior to completion of cause of death?
	The late has page						101	res 2EINo	1 ☐ Yas 2 ☐ No
of Vitai	sician: The law sirector, page 2 a o Be Compli	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)	
>	Physician: this certific ral director.	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outp	patient 3 DOA	Other: 4 Nursing	Home 5 Resid	dence 6 ☐Other (Sp	pecify)
	leath. tor: After this the funeral d cation: Te	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year)	28b. Tir Inj	ury	njury at Work? I 🗌 Yes 2 🗌 No	28d. Describe h	now injury occurred	
Division	her direct	3 Suicide 6 Could not be determined		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,			
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	To the comple	29b. Signature and title of certifier	Ino)			ense number 2 4 46		29d. Date signed (Mo	nth, Day, Year)
14	1	30. Name and address of person who	completed cause of death (II	tem 23a) (T	ype, Print)	Beltin			
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1.	Bultima	10,000	2.20	
	Registrar	JUL 3	1999 Den	was	D. D.	parks			

13,00

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	Maryle f sho	Į.	MD	Prince	Georges			Marlbo	ro				17⊠ Yes 2 □	
	the root	Director	10e. Street and Nu		0001900		ppci	10f. Zip Code			10g. Citizen of 1	What Cou	ntry?	
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Maryland 21215-0020	tural	b p	3 LJ Wildowed	15. Decedent's Edu	Yeer or Dataa:		16a Deced	ent's Usuai Occu	netion		16b. Kind of B		hite	
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mo	Page net c int: If iry or			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)				l Veter		8/4/99	Chelte	enha	m, MD	
Baltimore,	permit. Pages 1 and Department of Heelt Important: If Item 27 any Injury or other i		21. Signeture of Fu	unerai Sarvice Licens	900		22.	Nema and Addre	ess of Facility R	avmond	Funera	a 1 H	ome, P.	Α.
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687	ficete phys	edical	thet initiated events resulting in death)	Last		Due to (or	es e consequ	iance of):						
Вох	nding use a	Z			d									
	deeth e atte ed for	Physician/M	Pert ii. Other signif	ficant conditions con	ntributing to death b	out not result	ting in the un	derlying cause gi	ven in Pert I.	23b. Dld 1	tobacco use co	ntribute t	o the cause of de	ath?
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	8 68	by										T		
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n of	ding Phys h. After this funeral di		27. Manner of Deat	h 5 Pending	28a. Date of inju	ury by Year)	28b. Time of tnjury	28c. Inju Wo			how injury occur			
Sio	Attending or death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicida	investigation 6 ☐ Could not be					Yes 2 No	***				
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Ξ.	Hospital 24 hours a Funeral C etely filled		29a. Certifier	15 Certifying Phys	sician: To the best	of my know	ledge, death	occurred et the ti	me, dete end piece	, and due to the	cause(s) and ma	anner as s	tated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)	2 Madieal Exami	ner: On the basia o end mennar st	of axamination	on end/or inve	estigetion, in my	opinion, deeth occu	rred at tha tima,	data and place,	and due t	the ceuse(s)	
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5	,		30. Nema and addre	ess of person who co	ompleted cause of	death (item :	23e) (Type, F	Print)	201118	o mr	\am	,_	Pala	h
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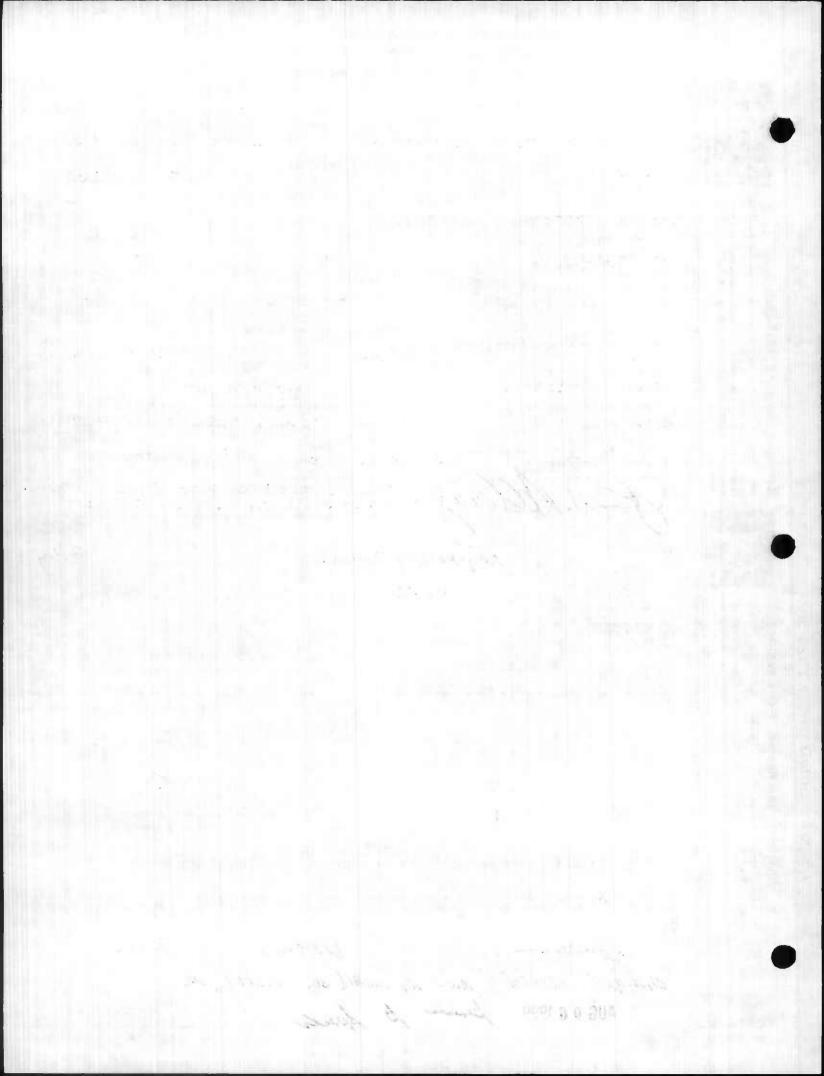


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ician			st)					2. Date of D		V	3. Time of Death	
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or	212-20- Usual Residence	5014	I□M 280 F	76	Yrs. Mont	ths Days	Hours Mi	May 2			yland	
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Funeral Director	10e. Street and N				-	Zip Code			10g. Citizen	of What Cou	untry?	
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ToB	William	Garfield	Hudgins				Myrtle	e Cullis	on			
-	19a. Informant's	Name/Relationship (Type, Print)		19b. Mailing Add	ress (Stree	et and Number or I			wn, Stete, Zi	ip Code)	
		Gahan/Son					Dak Lane,		_			
	20a. Method of Di			20b. F	Place of Disposition (cemetery, cremetory			Date	20c. Locatio			
		2 Secremation 3 ☐ 5 ☐ Other Specif			cemetery, cremetory Lisbury Cr			8/5/99	Salis	bury,	MD	
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DUCE		-M.K	uson	ves	501	Snow	Hill Rd.	, Salis	bury, M	D 218	04	
	23a Party Enter	r the disease, or com	plications that ceus one cause on each	sed the deat	h. Do not enter the	mode of dy	ring, such as cerdi	iac or respiratory	arrest,		Approximete interval Between	
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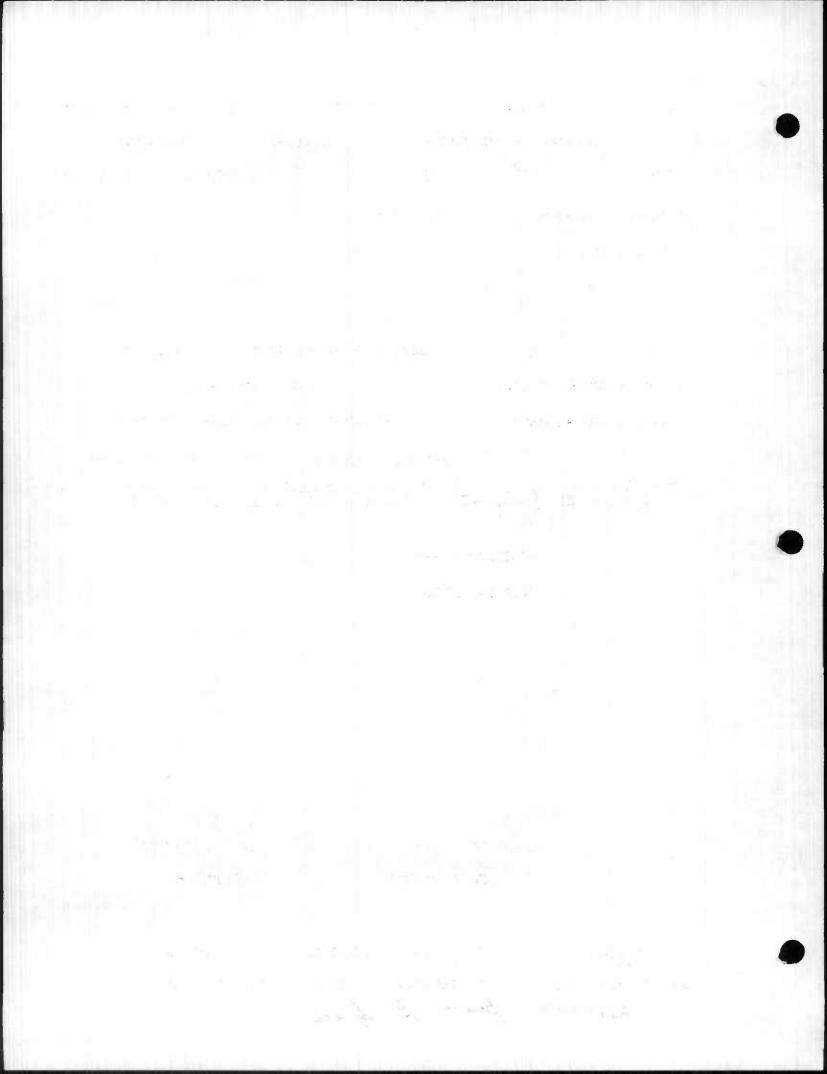
212.26-5014

HESTER GAHAN



State of Maryland / Department of Health and Mental Hygiene 99 26847

						Ce	rtificate	of	Death			Reg. No.		tem U	J
П	Dharata		Decedent's Name (First, Midd	le, Last)							2. Date of D Month	eeth	Vans	3. Tim	ne of Death
	Physic /Medi		JUDITH	AMANDA			GODW:	ſΝ			08	O8	Yeer 99	063	34
3	Exami		4a. Fecility Name (If not Institutio	n, give street and n	umber)				4b. City, Town	n, or Lo	cation of Dea	th 4c. Cour	nty of Death		
1			PENINSULA REGIO	ONAL MEDI	CAL CEN	TER			SALISB	URY		WICO	MICO		
	Funeral Director		5. Social Security Number 426–17–0201	6. Sex 1 ☐ M 2 【XF	7. Age (In yrs.	last birthday		Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bi (Month, D 06-03-		Cot	place (Stantry) Sissi	ate or Foreigi
Т	pu *	1	Usual Residence of Decedent 10a. State 10b. Counfy		10c C	ty, Town or L	ocation							40-1 11-	4- 6'- 11 1
	Ba-f sho	Director	Maryland Wico	mico		Salisb									le City Limits Yes 2 No
	ath with the 23s or 2	rai Dir	7917 Boylston	Bend			10f. Zip C	80	1			10g. Citizen d		intry?	
020	within 72 hours affer death with the Maryland ene. than "natural", or items 23a or 28a-f show tra Medical Examinat must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	Armed F ried 1 ☐ Yes	2 X No	J,S. 13.	Was Decede If Yes, specify 1 ☐ Yes 22	y Cub	an, Mexicen,	n? (Spe Puerto	ecify Yes or N Rican, etc.)		ace - Amer lack, White cify:		n,
5-0	thin 72 hours s. an "natural", Wed cal Ex	Completed	15. Deceder (Specify only highe	t's Education)	18a. Dece	dent's Usual	Occup	ation	f world	lna	16b. Kind of	Business/li	ndustry	
2	ithin	npie	Elementery/Secondary (0-12)	1	(1-4or 5+)		kind of work DO NOT use					71			
7	TO 120 A. THE	CO	12	2		Lice	nsed Pr	cac				Medio			
Maryland 21215-0020	a la b	To Be	17. Father's Name (First, Middle, Hubert Frankli		n						Ann Ewi	, Maiden Sum L ng	ame)		
	ss 1 and 2 should of Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations Karen P. Canno									er, City or Tow		ip Code)	
Baltimore,	Peges 1 nent of He ant: If Itan		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremetlon 4 ☐ Donation 5 ☐ Other (S		State	cemetery, cre	osition (Name matory or other ry Cren	er pla		8	Date 8/9/99	20c. Location			е
Balti	pemit. Pege: Department of Important: If I any Injury or once.		21. Signeture of Funeral Service	Licensee	Mol	051 H	2. Name and	Addre	ess of Fecility uneral			essionary, MD			ition
	Physician		23a. Part1. Enter the disease, or shock, or heart feilure. List	complications that only one cause on	aused the deal each line.	th. Do not en	iter the mode	of dyi	ng, such es ca	ardiec c	or respiratory	arrest,	2100	Approxi	mete Between and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. GUNS	HOT TO Due to (HEAD or es e conse	quence of):								
	D 15	ine		- SELF	INFLIC	TED							i		
68760,	eath certificate be executed attending physician and for use as the bunal-trensit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (d	or as a conse									
XO	ending p	ξ	, , , , , , , , , , , , , , , , , , , ,	d											
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ecord	been s	Completed										s an autopsy ormed?	a	Vere eutop vallable pr omptetion f death?	osy findings rior to of cause
Œ	0 - 0	E									1 🗆	Yes 2 No			2□ No
Viita	dentificate rector, pag	Be C	25. Was cese referred to medica						26 Place o	f Death	(Check only			L 100	
	Physician: this certific ral director,	0	examiner? 1 X Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Oth	or:			Idence 6 🗆 C	ther (Snec	ifu)	
o		Ë	27. Manner of Death		of Injury oth, Day Year)	28b. Time o		: Injui		T		how injury occ		''77	
o	Attending In death.	atio	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi			1155	М		rk? Yes 2 X ∫No	,	SELE_T	NFLICTE	כוז		
Division	or Attence after deatl Director:	fice	3 Suicide 6 ☐ Could	not be	e of Injury - At h		reet, factory, o	office		1	28f. Location	Street and Nur		al Route I	Vumber,
á	P# 5 =	Certification:	4 ☐ Homicide	build	BOYLST	(y)					City or To	wn, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai C	29a. Certifier 1 Cartifyin (Check only one) 1 Medicat	g Physician: To the Examtner: On the b	e best of my kno	wiedge, deat	h occurred at	the tir	me, date and popinion, death	olace. a	and due to the	cause(s) and	manner as	stated. to the cau	se(s)
	within 2 To the comple	Me	29b. Signature and title of certifie		mor states.		29c. l	icens	e number	-	· T	29d. Date sign	ned (Month	Day, Yes	ar)
	- s - ō		1	=63.01	M. D.	D.M.	E. DO	JU 3	599			08-08-9	_		
1.	/		30. Neme end address of person	who completed cau	se of deeth (Ner				JJJ			55 00 5			
	5		JOHN T. BULKELI					[TE	201,	SAL	ISBURY	MD 218	01		
	Sta	ite	31. Date filed (Month, Dey, Yeer)	32. F	Registrar's Signe	eture									
	Registi	ar	AUG 0 9	1999	Deper	0	10	au	6						

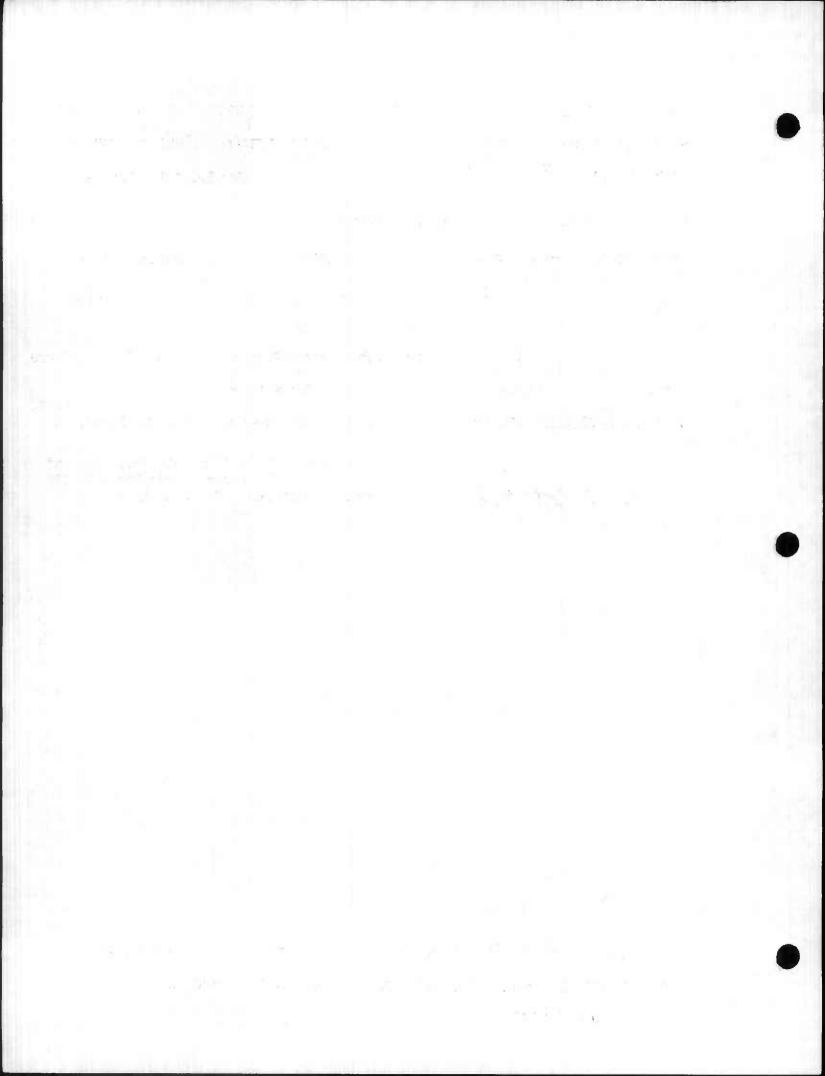


			nd #17	State of Ma	arylan cds		artmen <i>rtificati</i>			nd Mental		40	3 6	.6046
100	Jar	nes	Pinkney Gaddis 1. Decedent's Nama (First, Middia, Last		cus	Ce.	lillicati	e or i	Dealli	2. Data	Reg. of Death	. No.		3. Tima of Death
п	Physic		ADAM Marr			G	ADDIS	1		JULY	1	Day 26	Year 1999	9:10PM
	/Medi Examii		4a. Facility Nama (If not institution, giva	street and number)					lb. City, Tow	n, or Location of			ty of Death	J. IOIM
			2610 RITCHIE MARLE	ORO ROAD				J	JPPER	MARLBORG		PRINC	E GEO	RGE'S
10	Funeral Director		217-44-0441		88	last birthday) Yrs.	If Undar Months	1 Yaar Days	If Under 2 Hours	Min. (Mont	of Birth h, Day, Yo 10,	ear) 1911	9. Birthp Coun Mary	laca (Stata or Foreig try) Land
	land w		Usual Rasidence of Decedant 10a. Stata 10b. County		10c. City	, Town or Lo	ocation						1	0d. Insida City Limits
	Mary	to	MD P.G.		qU	per M	arlbo	ro						1□Yas 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	h the	Director	10e. Street and Number		2		10f. Zip	Code			10g	Citizen of	What Coun	itry?
	th wit		2610 Ritchie Marl	boro Road				20	0774			Unite	d Sta	tes
20	Jamithin 72 hours efter death with the Maryland jiene. I than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 Nevar Married 2 Married	12. Was Decedant I Armed Forcas? 1 ☐ Yas 2XX If Yas, Giva			Was Deced if Yas, spec	ify Cuba	ispanic Orig in, Maxican, Specify:	in? (Specify Yas of Puarto Rican, ato	r No-	14. Re	ce - Amaric ack, Whita,	an Indian,
8	houn lural		3√√Widowed 4 □ Divorced	Yaar or Datas:		10: D.		10	- 41		10			
15	in 72	Sete	15. Decedent's Edu (Specify only highast grad	a completed)		(Giva	dent's Usua kind of wor DO NOT us	rk dona d sa ratired	ation during most	of working	16	b. Kind of a	Businass/Ind	Justry
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	al Hygie other	Bec	17. Fathar's Nama (First, Middla, Last)							's Nama (First, M				
yla	should be nd Mental marked o	To	James James	Pinkney	Ga	ddis			Edit	h Marr				
Maryland	end end		19a. Informant's Name/Ralationship (T)				_							Code) 20774
	s 1 and 3 If Health Item 27 other tra		Anna Gaddis Rauch (20a. Mathod of Disposition	DAUGHTER)	20h P	ace of Dispo			Marib	oro Road			- City or To	
altimore,	0 0		1 Suriai 2 Cramation 3 F	amoval from Stata	C	ematary, cres	matory or or	thar plac						
alti.	교 등 은 증		21. Signature of Jurismal Sarvice Licens	90	cea	ar Hil			-	ly 30,19 Lee Fune				
ä	Depa impo any ir		V / 1KG	t 651						Road, C				
			23a. Paul. Enter the disease of complete the	ications that caused	tha death	. Do not ani	ar tha mode	a of dyin	g, such as c	ardiac or respirat	ory arrast		Ī	Approximata Interval Between
V	Physician		and the state of t										i I	Onset and Death
	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting In daath)	Ische	Tun	e M	yoca	nd	ropa	gry			1	months
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o.	thet the death certified by the attending detached for use e	Physician/M	Part II. Other eignificant conditions con	tributing to death bu	t not rasi	ilting In tha u	ndarlying ca	ausa giv	an in Part I.	23b.	Did tobe	cco use c	ontribute to	the cause of death
۵,	thet the detail		ATHOU FIBHING	nton							1 Yes	2 No	3 Prot	bebly 4 Unknow
Records,	w requires thet the death certif been signed by the attending should be detached for use e	Completed by	Prostate Ade	Att St	no	ma					Was an a performed		COI	are autopsy findings ailabla prior to mpletion of cause daath?
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n o	Ing Pt		27. Mannar of Deeth 1 ☑ Natural 5 ☐ Panding	28a. Data of tnjur (Month, Day	Year)	28b. Tima o Injury		8c. Injun Worl			ribe how	injury occu	irred	
Division of Vital	or Attending Physician: efter death. Director: After this certific in by the funeral director,	Certification:	Accidant invastigation 3 Suicide 6 Could not be determined	28a. Place of Injubulding, ato	ry - At ho	ma, farm, str	M reat, factory		Yas 2□N	28f. Locat	ion (Stree r Town, S		ber or Rura	l Routa Number,
_	Hospital	edicai Ce	29a. Cartifiar 1 Certifying Physical Check only one)	ician: To the best of her: On the bests of and manner sta	axaminat	vledga, daatl lon and/or In	n occurred a	at tha tin in my o	na, data and pinion, daati	placa, and dua to n occurred at tha t	tha caus	sa(s) and m	nannar as si	ated. tha cause(s)
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	- > - 0		Gerald	P. Ster	ne	Mo	D.	PI	724	7	J	TULY 2	27, 19	999

15 State Registrar

30. Nama end addrass of person who completed cause of dasth (Itam 23e) (Type, Print)

GERALD P. STERNER, M.D. 19 CHESAPEAKE BEACH RD. OWINGS, MARYLAND 20736 32. Registrer's Signetura



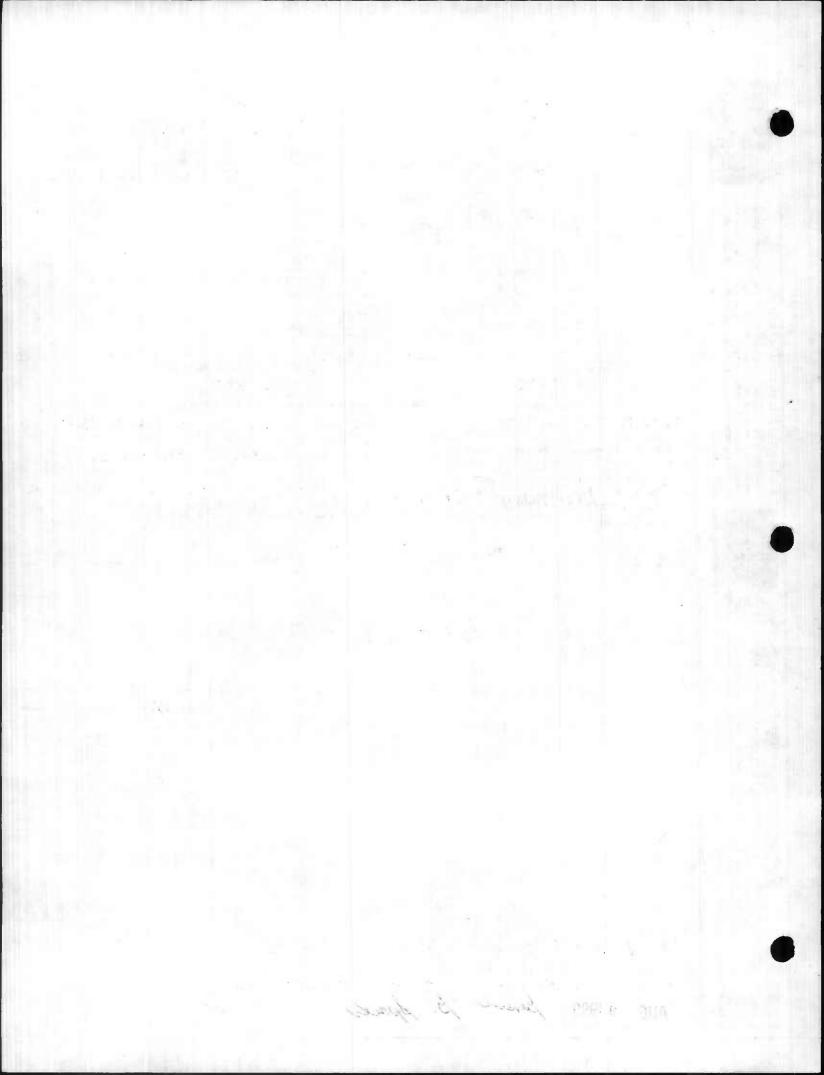
State of Maryland / Departn

ment of Health and Mental F	lygiene	0	0	9	***	0.1	
icate of Death	Reg. No.	2	1	6.1	9	0	

			Ce	rtificate	of D	eath		Reg. No.	2	20043
	1. Decedent'a Nama (First, Middle, L	ast)					2. Data of D Month		a.Vena	3. Tima of Death
Physician /Medical	ROBERT A.	HURFORD					Augus	t 6 Day	9499	2330
Examiner	4e Facility Name (If not institution, gi Easton Memoria					City, Town, or L Easton	ocation of Dea	th 4c. Count	y of Death Lbot	
Funeral Director	178-20-4583	Sex 7. Age (In yrs	. last birthday, Yrs.	If Under 1 Months I		f Under 24 Hrs. Hours Min.	8. Date of B (Month, D APR. 6			placa (State or Foreign ntry) SYLVANIA
2 3	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside City Limits
ster death with the Meryler or Neme 23e or 28e-f show inside ment be notified at PEUNERIA Director	MD TAL	BOT	ST. M	ICHAEL:				10g. Citizen of		1 □ Yas X2 □XNo
ath with 123e or Mari De ral Dir	9522 MARTINGHAM	_		10f. Zip C	216				USA	
9 4 6	11. Marital Status 1 Never Married 2 X X Arried 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates: WWTI		Was Deceder If Yes, specify 1☐ Yes 25		anlc Origin? (Sp Mexican, Puarto Specify:	pecify Yes or N Pican, atc.)	Speci	ack, Whita,	can Indian, atc. HITE
ed within 72 hours or than "natural", 1, the Marice Completed by	15. Decedent's E		(Give	dent's Usual (done dui	on ing most of work	king	16b. Kind of I	Business/Ir	dustry
within the the	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	retired)			gov.		A
	12 17. Father's Name (First, Middle, Las	4	EXE	CUTIVE	1	B. Mother's Nam	o /Eiret Middle			ATION
A SEE	CHARLES HENRY HU	RFORD				LILY	JONES			
0 = = =	19a. Informant's Name/Relationship					d Number or Rui				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	BETTY T. HURFORD 20a. Method of Disposition			MARTII osition (Name		M CIRCLE	E, ST.	MICHAEL:		
2520	1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removel from State	cemetery, cre ESAPEA	KE CREN	er place) MATI(ON CTR		STEVENS		
pemit. Pege Deperment of Important: If any injury of pngs.	21. Signature of Funeral Service Lice	mam II CF	F	2. Nama and A ELLOWS , 00 S . I	. HEI		& NEW	NAM FUNI	ERAL 1	HOME, P.A.
	23a. Part1. Enter the disease, or cor shock, or heart faiture. List only	nplications that caused the dea y one cause on each line.								Approximate Interval Between
Physician		64 . 1 1	0	1	1	2			i	Onset and Death
/Medical ' Examiner	Immediate Cause (Final disease or condition resulting in death)	· Multipl	e le	rebra	IE	mbol	1		1	9 days
- L			or as a conse	quence of):	1					UNK
7 SE		b. F10		w dit	75				-	UNI
burlet-frensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. UIC	or as a conse	quence of):	Coli	tis				one year
nd phy es the	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					1	
of the deeth ce d by the ettendi etsched for use Physician/	Part II. Other significant conditions	contributing to death but not re-	sulting In the u	underlying cau	ıse given	in Part I.	23b. Did	I tobacco une c	ontribute 1	to the cause of death?
aigned by the eld by Physic							1	Yea 2 No	3□ Pro	obably 4 Unknow
s been 2 shou			W				24a. Wa per	s an autopsy iomed?	a	Vere autopsy findings vailable prior to pmpletion of causa death?
4 - 5 - 5							1 🗆	Yes 2000	1	□ Yas 2□ No
yalclen: The s certificate director, par To Be Co	25. Was case referred to medical examiner?				- 2	6. Place of Dea	th (Check only	one)		
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nding Printh. Tr. After the funeral atlon:	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 280	o. Injury a Work? 1 ☐ Ye	s 2 No	28d. Describe	how injury occu	irred	
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To the Mospital or Attanding Phywithin 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification: T		hysician: To the best of my kni miner: On the basis of examination and manner stated.								
Meithin Meithin Somple	29b. Signature and title of certifier	11.		29c. L	Licensa n	umber		29d. Date sign	ed (Month	Day, Year)
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	30. Name and address of person who SUSAN T. FORLIF				712 *	A CMON	MD 2166	11		
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State Registrar	31. Date filed (Month, Day, Year) AUG 9 1999	Dever	· Ap	outs						

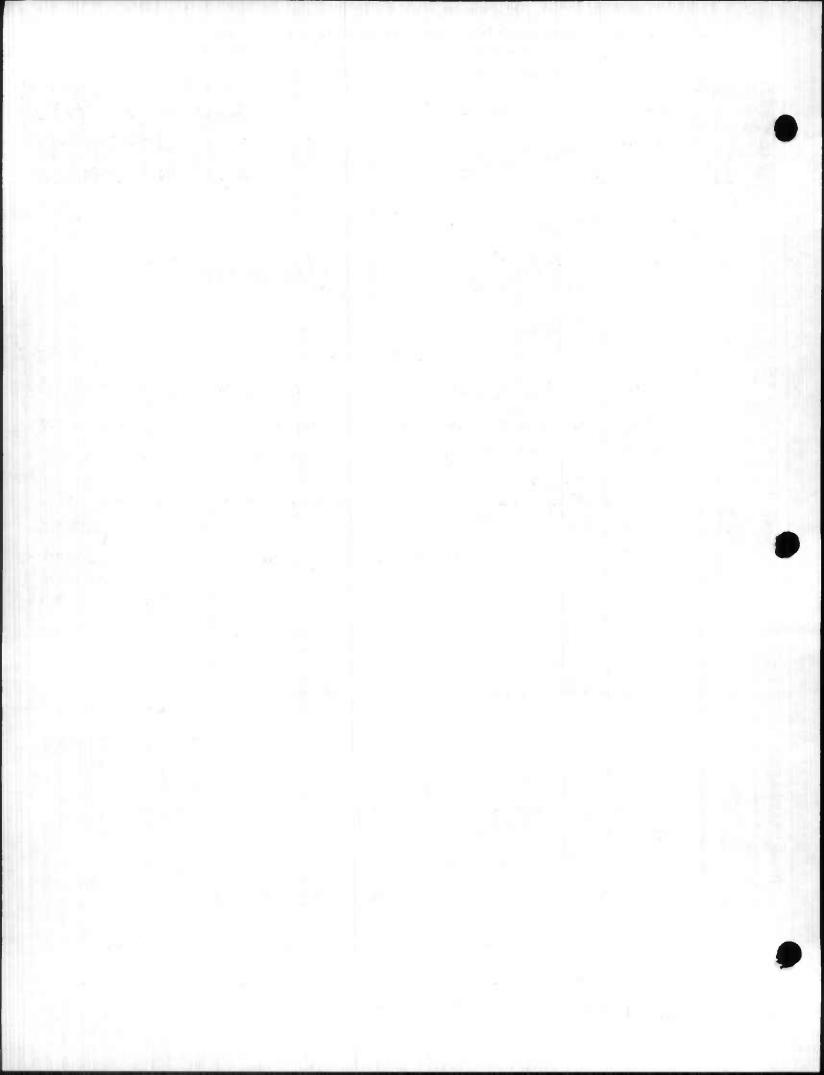
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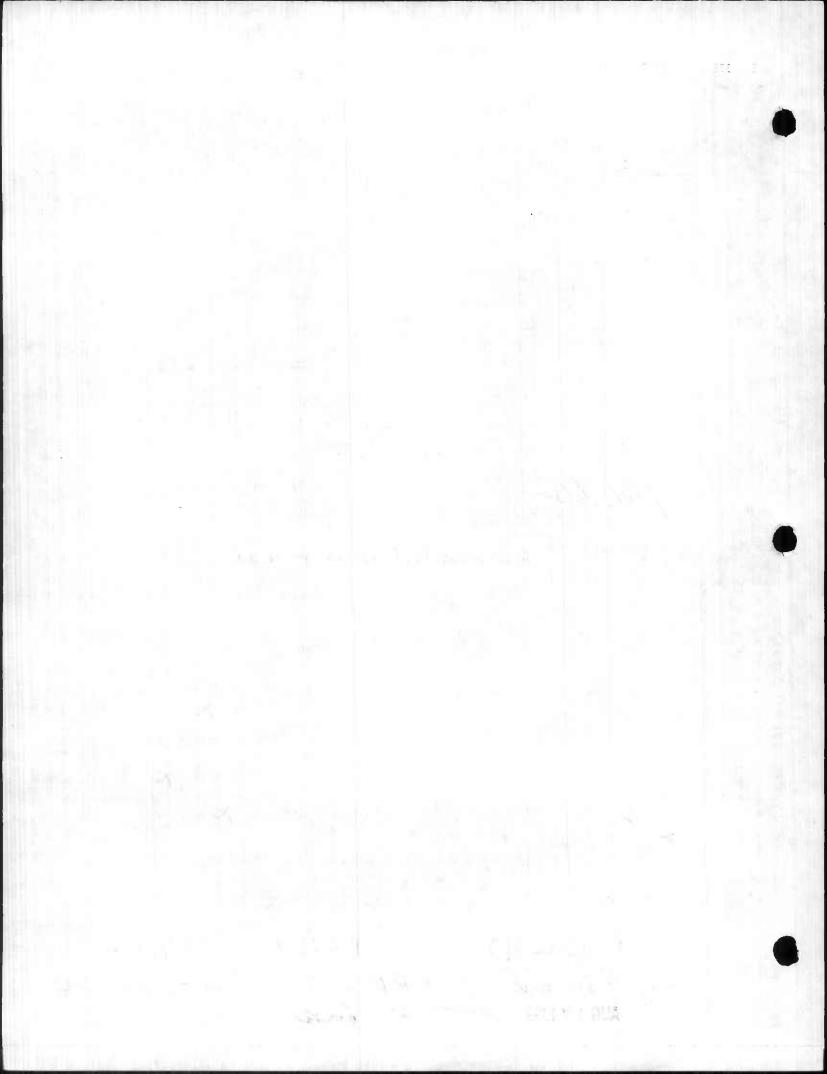


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylar		ent of Health and ate of Death	Mental Hy	rgiene 9	9 26	850
Physic /Medi	cal	Decedant's Nama (First, Middla, Less) ARY GINGE 4a. Facility Name (If not Institution) give	R HAMILTO	N	4b. City. Town, o	2. Data of Do Month AUGUS Location of Deat	Dey 14 /	Year 1	ma of Death
Funeral Director	ner	5. Social Sacurity Number 6. Si 217 -46-1355	ital	last birthday) If Und Yrs. Month	ECK +C	s. 8. Data of Bi	CE	9. Birthplaca (S	Stata or Foreign
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20 arrive	by	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar In U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	If Yas, s	pedant of Hispanic Origin? (pecify Cuban, Maxican, Pua	Specify Yas or Norto Rican, atc.)	o- 14. Rac	ce - Amarican Indi ck, Whita, atc.	an. te
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Baltim pemit. Pag Department Important: I any Injury o		21. Signatura of Funeral Sarvica Juni		22. Nama	and Addrass of Facility Fig. No. 2 / H	dome 2	CG EN	MAIN S	<i>t</i> :
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icate be executed physician and s the burial-transit	ai Examiner	Saquantially list conditions, if any, leading to immediate ceuse. Entar Undarlying Causa (Disaasa or Injury	b. Due to (c	or as a consequance o	1):				
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hat tha	Physician/M	Part It. Other significant conditions co	ntributing to death but not ras-	ulting in tha undarlying	g causa givan In Part I.		tobacco use co	ntributa to the ce	
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io		30. Name end address of person who c	Mulleted cause of death (Item		D04823		P 15	199	
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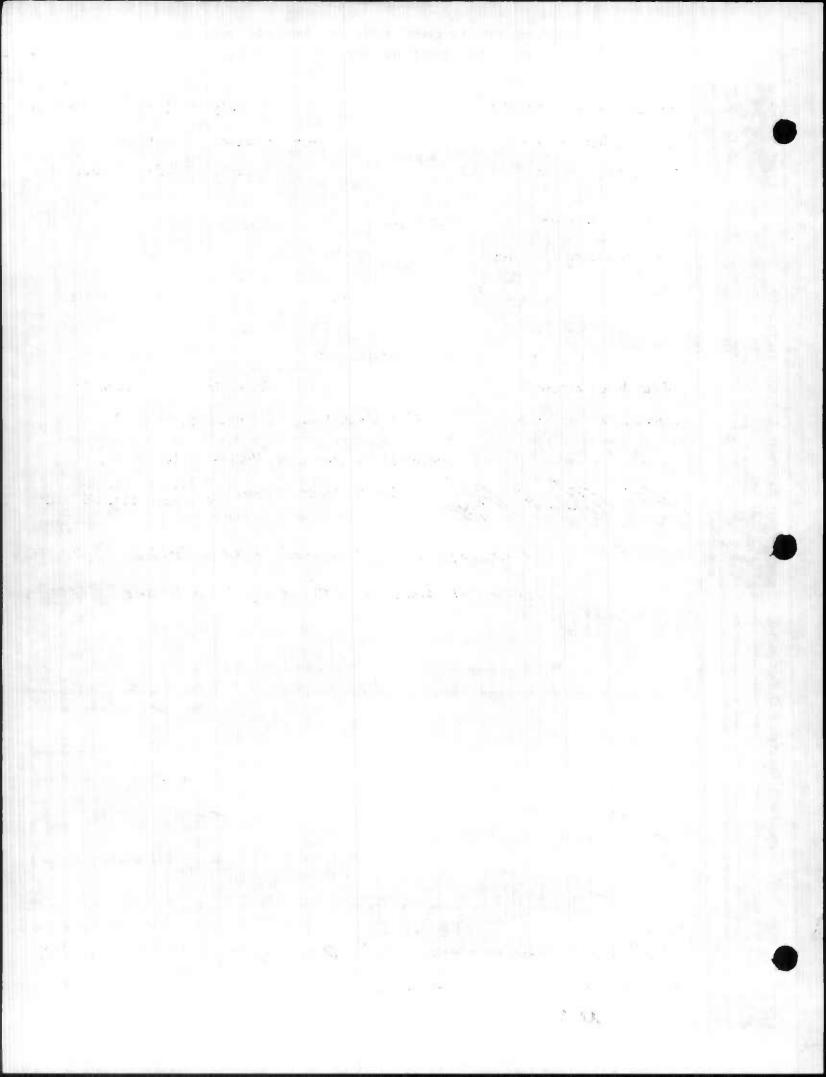


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State of Maryland / Department of Health and Mental Hygiene 99 26852

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Inter death with the Mar thems 22s or 28s-f st kiner must be notified Funeral Director	MD Somerse 10e. Street and Number 31109 Eden Allen		Eden	10f. Zip Code	-	10		1 □ Yas 2 √ No What Country?	
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State Registrar

AUG 0 5 1999

Spark

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I. Decedent's Name (First, Middle	, Last)						2. Data of De			3. Tima of Deat		
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PENINSULA REGI			men.						4c. County of Deeth			
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State

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death cartificets be executed within 24 hours after death.

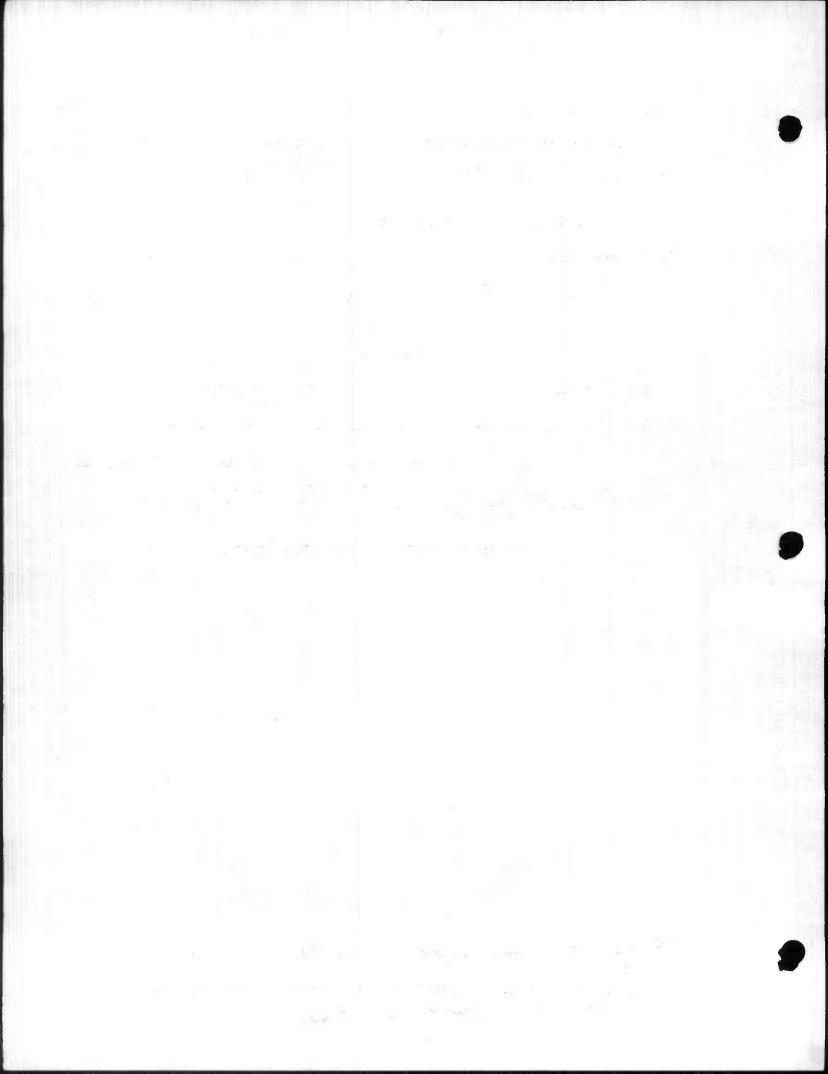
Within 24 hours after death.

The Funeral Director: After this cartificete has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the bundar-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar



State of Maryland / D

	2. Dete of Death	Dav	Year		3. Time	e of D	6
Certificate of Death	Reg. f	No.	10	6	58	5	
epartment of Health and I	Mental Hygier	ne ,	2.0	_	00	Pirron	

Physician /Medical Examiner

Timothy Edwin Hay 4e Facility Name (If not institution, give street and number) ROUTE 260 1/4 MILE EAST OF ROUTE 778

AUGUST 2, 1999 4b. City, Town, or Location of Death

ath 1720 PM

Funeral

28e-f 2

mant be r

Pages 1 and 2 should be fled within 72 hours after nearl of Health and Mental Hygiene.

Intel if Item 27 is merked other than "natural", or ite ury or other traumetic event, the Medical Examins

Baltimore, Maryland 21215-0020

5. Social Security Number 6 Sev M 2□ F 219 17 0969

1. Decedent'a Name (First, Middle, Last)

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year)

OWINGS

4c. County of Death CALVERT

Director Usual Residence of Decedent

Director

Funeral

þ

Completed

Be

10a State 10h County MD Calvert 10c. City, Town or Location Huntingtown May 23, 1974

 Birthpiace (State or Foraign Country) Wash.

10d. Inside City Limits

1 Tyes 2 DKNo

10e. Street and Number 721 Bowie Shop Road 10f. Zip Code 20639 10g. Citizen of What Country?

USA

11 Marital Status

Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:

14. Rece - American Indien, Bleck, Whita, etc. white

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) 5+

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired)

16b. Kind of Business/Industry

college

Elementery/Secondary (0-12) 17. Father's Name (First, Middla, Last)

Richard Isaac Hay

18. Mother's Name (First, Middle, Meiden Sumama)

Carolyn Rose Potter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

19a. Informent's Neme/Reletionship (Type, Print) Richard I. Hay (father)

PO Box 927, Huntingtown, MD Date

20639 20c. Location - City or Town, Stete

20a. Method of Disposition

1 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place) Miranda Cemetery

student

8-6-99

Huntingtown, MD

21. Signature of Funeral Service Acenses

22. Name end Address of Facility

Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

the burial-transit

80 950

signed by t

page 2 s certificate

Completed by

Be

Certification: To

Medical

physician

The law requires that the death certificate be executed

or Attending Physician:

Hospital

0

After this funeral

the

filled in by

completely

24 hours efter death.

Within 2 \$

Box 68760.

of Vital Records, P.O.

Division

Department of Important: If any Injury or

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Immediate Cause (Final disease or condition resulting in deeth)

MULTIPLE INJURIES

Due to (or as a consequence of)

25a Parti. Enter the disease, or complications was caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line.

Due to (or es a consequence of):

Due to (or as e consequence of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yea 2 XXIo 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

XXYes 2 No

26. Place of Deeth (Check only one)

XXYes 2 No

25. Was case referred to medical examiner? 1XXYes 2□ No

27 Menner of Death

1 Natural

2XXAccident

4 Homicide

3 ☐ Suicide

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

08/02/99

28b. Time of Injury 1715

Other: 4 Nursing Homa 5 Residence 6 X ther (Specify) SCENE 28c. Injury at Work? 1 Yes 270 No

28d. Describe how Injury occurred DRIVER IN AUTO ACCIDENT

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) ROUTE 260/ROUTE 778

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) AUGUST 3, 1999

d address districts who completed cause of death (Item 23a) (Type, Print) Ann Dixon M.D.

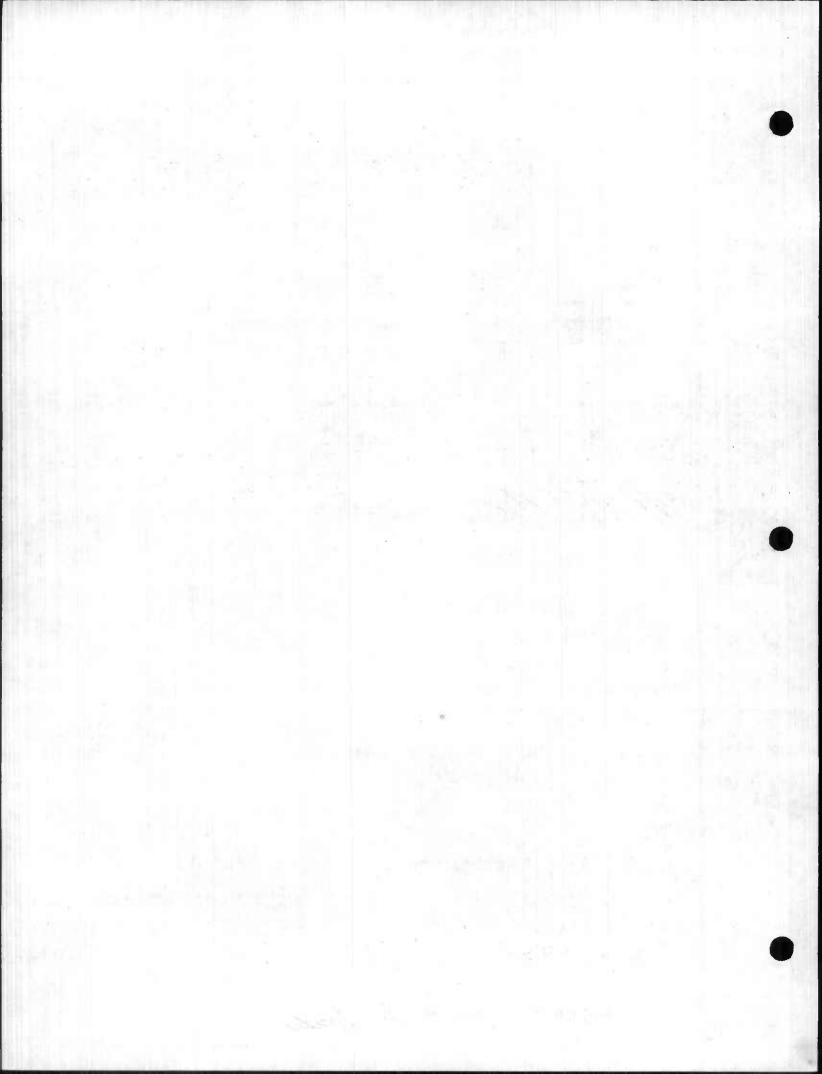
29b. Signature and title of control

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year) AUG 06 32. Registrer's Signeture

Sporks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** HAYDEN 2:53P HORACE March Philip /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hunder 24 Hrs. Hours Min. CITY JOHNS HO5 Baltimore City 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2 F 577-52-2098 1937 Director 61 Washington, DC Usual Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If term 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event. In a second of the contract 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yas 2 ☐ No Director Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45H Queen Neva Court 21619 Funeral 12. Was Decedant Ever In U.S. Armed Forces? 1 ☐ Yas 2 ₺ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Physic Engineer 4 Dept. of Navy 17 Father's Name (First Middle Last) 18. Mother'a Name (First, Middla, Maidan Sumame) Be Bess Whiting Unknown Hayden 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) Ruth Anne Hayden 45H Queen Neva Court March 17, 1999 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Oxcremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center LLC | Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, PA 106 Shamrock Road, Chester, MD cons that caused the death Do not enter tha mode of dying, such as cardiac or raspiratory arrast **Physician** /Medical Immediate Cause (Final OBLITERATIVE BRONCHIOLITIS disease or condition rasulting in daath) Examiner Examiner post right single.
Due to (or as a consequence of): physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last thet the death certificete be axec a Chronic Obstructive Pulmonary Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 88 USB signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 has Yes 1 ☐ Yes 20 No 2 No certificate Hospital or Attending Physician: 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funerai 28c. Injury at Work? 27. Mannar of Daath 28d. Describe how Injury occurred 28b. Tima of 1/Matural 2 Accident 5 Pending 1 Yas 24 hours after deeth.

Funeral Director: A investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical Examiner: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date aigned (Month, Day, Year) 29c. License number 29b. Signature and the of certifier MARCH 15. 30. Name and addrass of parson who complated causa of daath (Itam 23a) (Type, Print)

Registrar

State

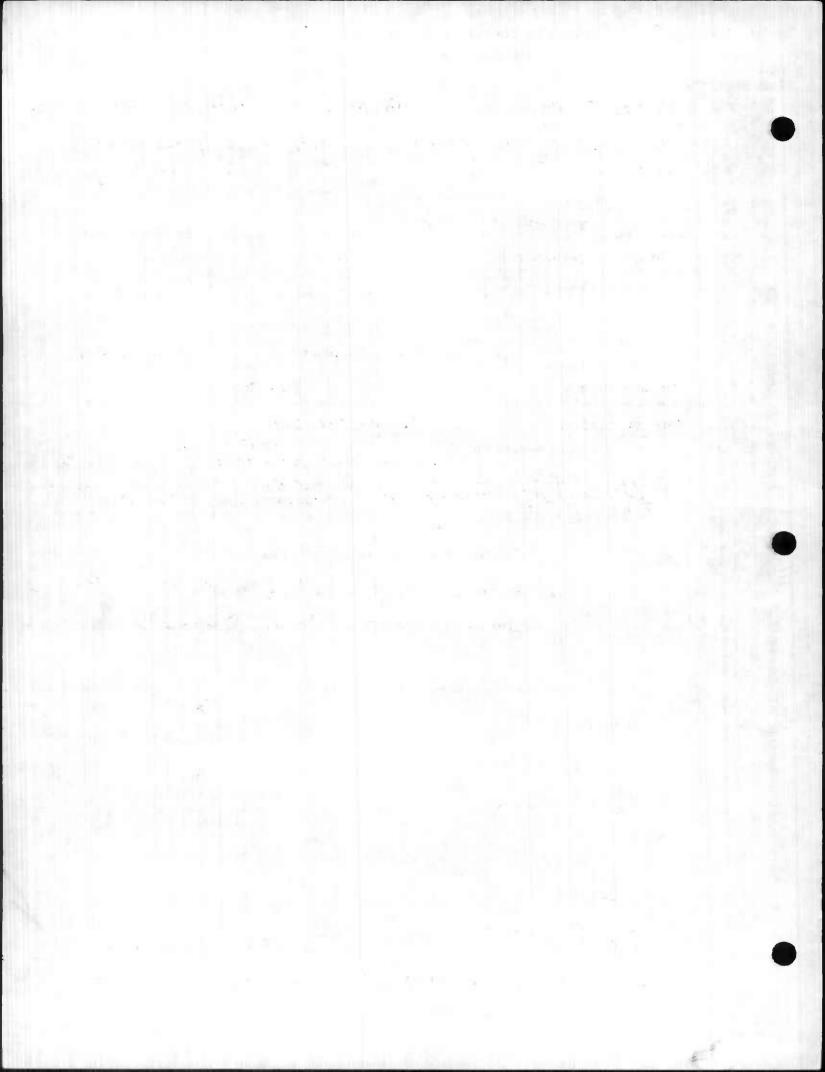
NEIL C. EVANS, 31. Date filed (Month, Day, Year)

MAR 1 8 1999

MD

32. Registrar's Signature Devera

600 N. Wolfe Street BALTIMORE, MD 21287



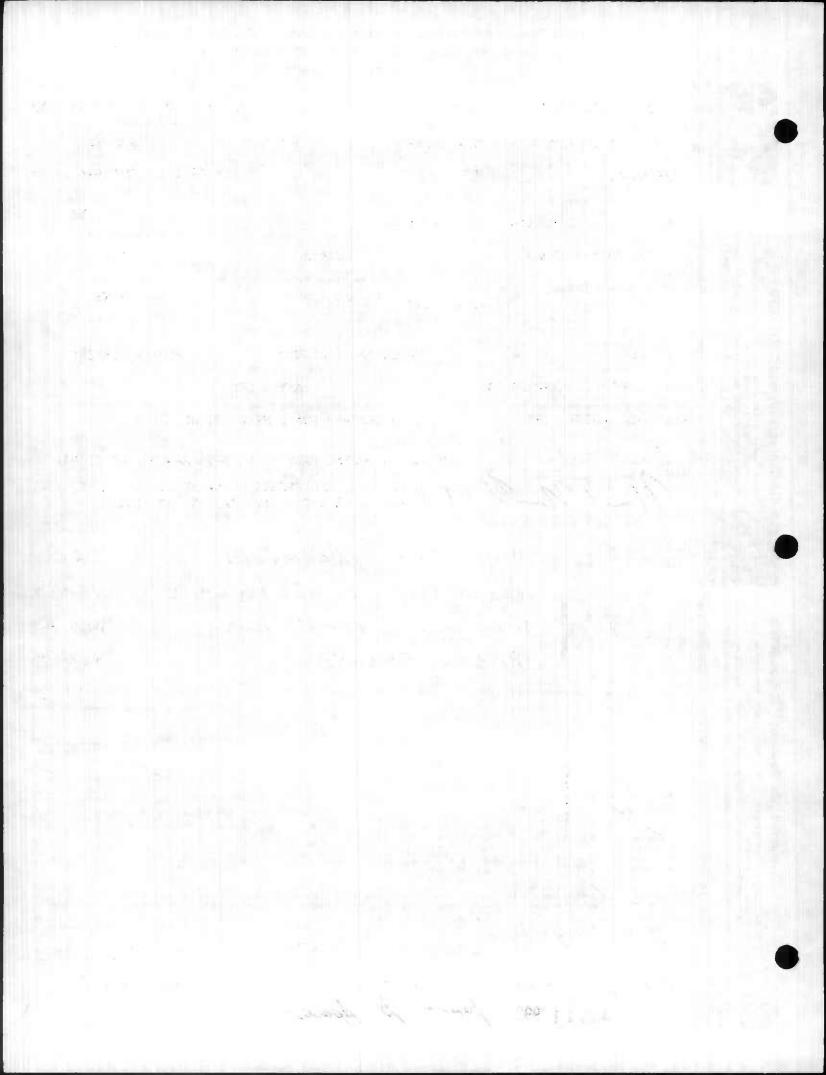
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Carl MACFARLANE August 10 1999 10:30AM Jones · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Genesis ElderCare -The Pines Easton Talbot If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours Min 86 Yrs. JULY 10,1913 Director 228-09-0792 GEORGIA Usuel Residence of Decadent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits f is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director MD CAROLINE PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21135 TANYARD ROAD 21655 USA permit. Pages 1 and 2 should be filed within 72 hours after death very popertment of Health and Mental Hygiena. Important: If frem 27 is marked other than "natural", or thems 23, any Injury or other traumatic event, the Medical Examiner name. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
1 □X/ss 2 □ No
If Yes, Give
Year or Detes:1 942-1947 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Merried 2 Married Maryland 21215-0020 Specity:WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 INDUSTRIAL ENGINEER POSTAL SERVICE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILLIAM MACFARLANE JONES AMY ALLEN 0 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALICE C. JONES/ WIFE 21135 TANYARD ROAD, PRESTON, MD 21655 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriel 2 Cremetion 3 Removal from State WOODLAWN MEMORIAL PARK 8-13-99 EASTON, MD 21601 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Liga 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Box 68760, Physician/Medical the attending | FAILURF signed by the a 23b. Did tobacco use contribute to the causa of death? Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed peen page 2 certificate has 1 Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetlent 3 DOA this funeral 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dev Year) 1 Natural 5 Pending 1 Yes 2 No death. Investigation 2 Accident or Attend after death Director: 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completaly filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of inxumination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only 29d. Dete signed (Month, Day, Year) 29b. Signature and title of be 29c. License number 30. Name and address of person who completed cayse of deeth (Item 23e) (Type, Print) E. MAKAS 32. Registrat's Signature 508 IDLEWILD EASTON, MA

State Registrar

DANIEL 31. Date filed (Month, Dey, Year)

AUG 11



State of Maryland / Department of Health and Mental Hygiene

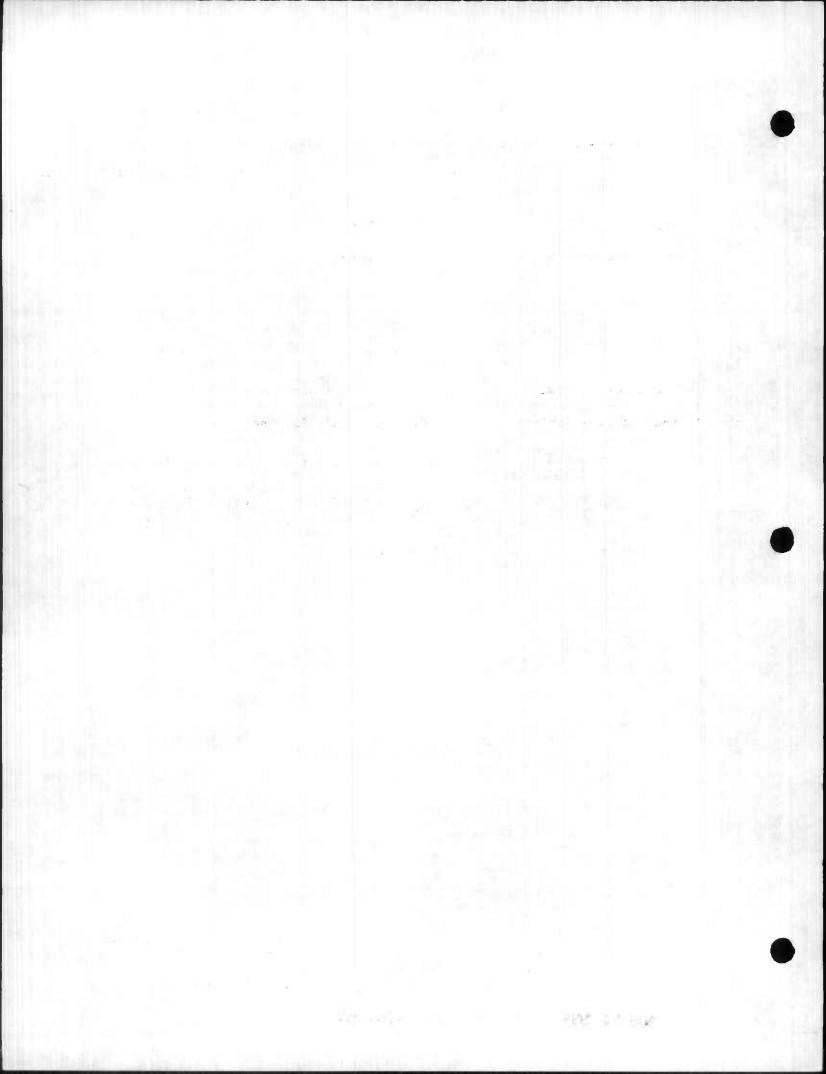
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Physi	cian	1. Decedant's Nama (First, Middla, I		-			2. Data of I Month 08		Dey Year		3. Tima of Death	
/Mec				ENKINS					-	99	10:00AM	
Exam	iner	4e. Fecility Nema (If not Institution, g					4b. City, Town, or Lo	ocation of Deeth	4c. County	of Deeth		
		CAROLINE NURSIN			T WILL		DENTON	1	CARO			
Funera Directo		5. Social Security Number 6. 218-34-7590 Usual Rasidance of Decedant	- D	ga (In yrs. last bir	Yrs.	ar 1 Yeer Days	if Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, MAY 16,	Year) 1907	9. Birthpli Count MARY	aca (Stata or Foreign ry) LAND	
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o Maria	Director	MD TAI	BOT	T	LGHMAN						Y Yes 2□No	
of terms 234	ë	10e. Street and Number			10f. Z	ip Code		10	g. Citizan of V	What Count	ry?	
	62	21528 GIBSONTOWN	ROAD	D 216					USA			
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72 hours natural,	B	15. Decedant's	Education	16a.	Decedant's Us	ual Occup	pation	1	6b. Kind of B	usiness/Indi	ustry	
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should b nd Ment marked umadic	10	JOHN B. HARRISO	N				LOTTIE E	. COVING	TON			
d 2 should th end Mer 7 is marks traumatic		19a. Informsnt's Name/Ralationship	(Type, Print)	19b.	Mailing Addra	ss (Street	and Number or Run	al Route Number,	City or Town,	Stata, Zip	Code)	
		DAVID L. McQUAY,	NEPHEW	P	O. BOX	207	TILGHMAN	N, MD 216	671			
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or Attending after death. Director: After In by the fune	Certification:	2 ☐ Accidant invastigati 3 ☐ Suicida 6 ☐ Could not	he									
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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	-	29b. Signature and title of certifler	= 1L		10 2	c. Licens	se number	29	29d. Date signed (Month, Day, Year)			
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		30. Nama and addrass of person who	completed causa of	daath (Item 23a) (Type, Print)						hattanag van van van	
		WAFIK ZAKI, M.	D., 920 MA	ARKET CT	DEMT	ON A	m 21620					
S	ate	31. Data filed (Month, Dey, Yaer)	32. Ragist	ra/s Signature								
Regis		AUG 1	3 1999	Geneva	Ø.	100	uh					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Maxine VanDyke Jamison 13:15 11, 1999 August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace H If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Harford Memorial Hospital Harford If Under 1 Ye 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 1□ M 2\ F Months 92 October28,1906 Pennsylvania Director 217-50-1186 Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1 ¥ Yas 2 □ No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Chesapeake Drive 21078 death Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglena. Important: if item 27 ie marked other than "natural", or having highly or other transment. Black, Whita, atc. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In her own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 0 Joseph Lee VanDyke Anna Belle Blair 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) James VanDyke Jamison P.O. Box 4027, Pinehurst, North Carolina 28374 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition August 14 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens | 1999 Aldino, Maryland 21. Signature of Funaral Service Licenses 22. Nama and Address of Facility Madelyn Mitchell Shank - Crouch Funeral Home hand 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** NEUMON Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner iclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initisted events resulting in death) Last Due to (or as a consequence of): Box 68760 physician certificate be Physician/Medical the Due to (or as a consequence of) 80 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by POLATID STENOSIS 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu 1 Yas 2 No this certificate 1 Yas 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 20 No 2 1 Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After I Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide filled in t The Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only 29b. Signature and title of certifie 29d. Date signed (Mdnth, Day, Year) /Dery 30. Name and address of person who completed cause of death (Nem 23a) (Tyge, Print) 32. Registrar's Signature 31. Data filed (Month, Day, Year) State 13 1999 Registrar



ysician	1. Decedent's Name (First, Middle, Last) Alphonso Johnson								2. Dete of Dea Month JULY 2	Day	Year	100	of Death) PM.	
Medical aminer	4a Facility Nama (If not institution, give street and number) RT. 2 AND 4 SOUTH AT SAWMILL RD. 4b. City, Town, or Low Lusby							ocation of Death 4c. County of Death Calvert				111.		
eral ctor	215-88-3444	215-88-3444 1₫M 2□F							Hours Min. 8. Date of Birth (Month, Day, 1)			9. Birthplaca (Stata or Foreig Country) 1973 Maryland		
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To	19a. Intormant's Name/Reletionship (Sheila Johnson/Mo	***		511	Baffo	rd R			ai Routa Numbe	20657				
	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funaral Service Licer	ata C	20b. Place of Disposition (Nama of camatary, cramatory or other place) St. John UMC Cemetery 7/3 Southern Mem. Gardens 22. Name end Address of FacilitySewe1						Data 20c. Location - City or Town, Stata /30/99 Lusby, MD Dunkirk ell Funeral Home ad Prince Frederick, MD 206					
of for use as the burial-transit	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disassa or Injury that inkited events resulting in death) Last	b		or as a consecutive as a consecu										
Physician/Med	Part II. Other eignificant conditions o	ontributing to deat	h but not ras	ulting In the u	nderlying c	ausa giva	an in Part I.		23b. Did to	obacco use co			e of death	
Completed by									24a. Was a parfor		av	ara autops ailable pric mpletion o death?	or to	
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completely filled in by the funeral director, par Medical Certification: To Be Co	axeminar? OXyas 2 No	7/23/ 28a. Place of	Injury Pay Year) 99	28b. Tima o Injury 1500 oma, tarm, str	b M	8c. Injury Work 1 🔲	er: 4□ Nu	rsing Ho	ome 5 Rasid	ence 6 XOoth ow injury occur c(# C) C C i	dent	al Routa N	INE	
edical Ce	29a. Cartifiar (Check only one) 1 Certifying Ph	niner: On the basis	s ot axamina								anner as s	tated.		
Mec	29b. Signetura end titre of certifiar 29c. License number O.C.M.E.								JULY 24, 1999)	
	30. Nama and address of person who	complated causa of				eet.	Ralt	imoi	re, Mary	land 21	201			

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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** FT.WOOD 1999 HARVE'Y **JACKSON** August 7, 7:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 Carey Avenue Salisbury Wicomico 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□ F Days Yrs. 217-36-0797 91 March 21, 1908 Director Maryland Usual Residence of Decedent the Marylend permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic evant, the Med at Example must be notified anone. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Salisbury Maryland Wicomico Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Carey Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White p 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farming Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey A. Jackson Julia A. Hay 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Thompson/Daughter 305 Carey Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/10/99 Sudlersville Cemetery Sudlersville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association M01051 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Ovro Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical · Prostate Cancer Examine Examiner Cerebratrascular event, C.V. A. physician end s the burial-transit The law requires that the deeth certificeta be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Completed by Physician/Medical IN Fection 80 use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PARKIDSON'S disease , degenerative 24b. Were autopsy findings available prior to 24a. Wes an autopsy periormed? APHASIA completion of cause of death? certificate has t lirector, page 2 s 1 ☐ Yes 2 M No 1 ☐ Yes 2 ☐ No al or Attanding Physician: The safter death.

I Director: After this certificated in by the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director, participated in the funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after Funeral Dire-pletely filled in the 4 Homicide edicai 29a. Certifier 1 🛣 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

540 Riversides

State Registrar

Smith

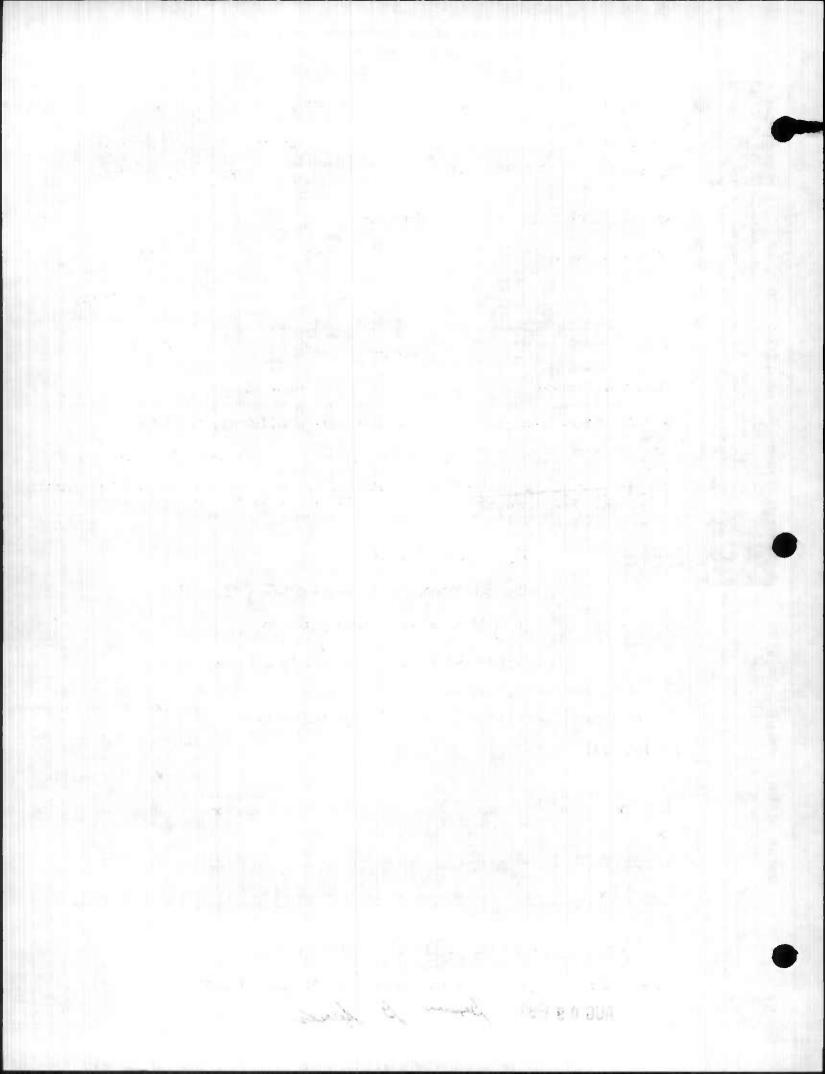
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31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** ALICE MARIE JONES AUGUST 1999 17:03 p.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Undar 1 Yaar Months Days if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 932 5. Social Sacurity Numba 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foreign Country) Maryland **Funeral** 1□M 21 F 67 Yrs. 214-26-3844 Director Usual Rasidence of Dacedant tha Maryland 10a. Stata 10b. County 10d. Insida City Limits 10c. City, Town or Location 7 is merked other than "naturel", or iteme 23a or 28a-f show traumatic event, its Mosical Examinar must be notified at 1 Yas 2 No Director Maryland Calvert Huntingtown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20639 4001 Houston Lane Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after 1 Navar Married 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Black. þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decadant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry permit. Pegas 1 and 2 should be filed within 7 Department of Health and Mantal Hygiane. Important: if Item 27 Is merked other than "n any Injury or other traumatic event. Elemantary/Secondary (0-12) College (1-4or 5+) Someone else's home Domestic 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Sumema) Robert Jacks Emma Rice 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 4009 Houston Lane Huntingtown, MD 20639 Ronald Jones/Son 20a. Method of Disposition 20b. Piaca of Disposition (Nama of cametery, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from State Patuxent UM Church Cem. 8/13/99 Huntingtown, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Sewell Funeral Home 21. Signatura of Funaral Sarvica Licensee p 9. Jerre 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician theroscienta Condro-/Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Vascular OBeare Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immadiate causa. Entar Undarlying Causa (Diseesa or injury that initieted events resulting in daath) Last and Due to (or as a consequence of): physicien at s the burial-t Box 68760, tha Dua to (or as a consequanca of): P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings availabla prior to complation of causa of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter daath.
Funeral Director: Attar this cartifica staly filled in by the funeral director, I 25. Was casa rafarrad to madical axaminer?
1 □ 7as 2 □ No 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 DER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not ba 3 Suicida 28e. Place of Injury - At homa, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the causa(s) and manner as stated. Medical 29a, Certifian 2 Medicat Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at tha time, data and place, and due to the cause(s) and mennar stated. 29b. Signatura and titia of certifiar 29c. Licansa numbar 29d. Data signad (Month, Day, Year) D-22634 30. Name and addrass of parson who completed causa of daath (Item 23a) (Type, Print) DR. MAHESH P SHAH, M.D. Prince Frederick, Maryland 31. Data filed (Month, Dey, Year) 32. Ragistrar's Signatura State Registrar Geneva **DHMH 16 Rev 6/95** AUG 1 1 1999

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State of Maryland / Department of Health and Mental Hygiene

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21215-0020 d within 72 hours efter deeth with the Meryland gigene.	ector		5. Social Security Number 6. S 409-42-4434	l Hospital	4a. Facility Nama (If not institution, giva street and number)				4c. County of		
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d 2	ner traumatic		19a. Informant's Name/Ralationship (Rachel Smith/Sist		1	19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 1015 Coster Road Lusby, MD 20657					
l sel	ages ant of tt: If h y or c		20a, Mathod of Disposition 1 XBurial 2 Cramation 3	Ramoval from Stata		Disposition (Nama of y, cramatory or other p.				ty or Town, Stata	
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D et	the funeral o	tior	1 ☑Natural 5 ☐ Panding 2 ☐ Accident Investigation	28a. Data of Injur (Month, Day	Year) II	njury W	ork? □Yas 2□No		.,,,,		
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To the Hospital or within 24 hours at To the Funeral D	completely filled in by	edicai C	29a. Cartiflar (Check only one) 1 Cartifying Ph 2 Medical Exam	ysician: To the bast on the bast of and manner state	axamination and	, daath occurred at tha d/or invastigation, in my	tima, data and place opinion, daath occu	, and dua to tha cau	usa(s) and mann ta and place, an	ar as stated. d dua to tha causa(s)	
othe ithin	omple	Mec	29b. Signatura and titla of certifiar	and marmar sta		29c. Licar	nsa numbar	29	d. Data signed /	Month, Day, Year)	
⊢ ≱ ⊢	- 0		- June 6	10.			17313		7/31	99	
			30. Name and address of person who	7. WWW			1 1010		, , 31	14	
+1				complated causa of da		ince Fred	lerick. M	ID 2967	7.8		
	Stat		31. Data filed (Month, Day, Year)		s Signatura	A LICE PLEO	de Long P	2507			

DHMH 16 Rav 6/95

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			Certificate of	Death	Reg	J. No.	26864	
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	D V	3. Time of Death	
Physician (Modical	HARRY RAYMOND L	YONS			Month AUGUST	13 1999		
/Medical Examiner	4a Facility Neme (If not institution, give street	and number)		4b. City, Town, or Lo		4c. County of De		
Examiner	MEMORIAL HOSPITA	T. GEASTON		EASTON		TALBOT		
Euparal	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Yea		8. Date of Birth	0.8	irthplace (State or Foreig	
Funeral Director	220-01-6710	76	Yrs. Months Deys	Hours Min.	Month, Day, Y AUG. 22,	1922 M	ARYLAND	
and w	10a. State 10b. County	10c. City, Tow	n or Location				10d. tnside City Limits	
dany feh	MD TALBOT	E	ASTON				XXYes 2□ No	
the port	10e. Street and Number		10f. Zip Code		100	. Citizen of What (Country?	
fier death with the Maryland ritems 23s or 28s-f show intermust be notified at Funeral Director	30588 KINGSTON ROAD		21	601		USA		
020 urs after Nr, or he	3 ☐ Widowed 4 ☐ Divorced Y	es Decedent Ever in U,S. med Forces? Yes_2_No Yes, Giva ear or Dates:	13. Was Decedent of the Yes, specify Cu		ecify Yes or No- Rican, etc.)	cify Yes or No- lican, etc.) 14. Race - Ame Black, White Specify:		
21215-0 ed within 72 ho ygjene. ver than "naturi rt, the Mexical Completed	15. Decedent's Education (Specify only highest grade com		Decedent's Usual Occu (Give kind of work done	pation	16	6b. Kind of Busines	ss/Industry	
within see.	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. DO NOT use retir	ed)				
d with giene.	-0		FARMER		AGRICULT		rure	
S should be filed and Mental Hygies marked other aumatic event,			18. Mother		(First, Middle, Ma	iden Sumame)		
Maryiand 42 should be file th and Mental Hy 7 te marked othe traumatic event	HARRY H. LYONS			ESTE	ELLE FIRST			
Shound N and N	19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,							
Man de la la la la la la la la la la la la la	M. BURNETT LYONS / E	ROTHER 3	0588 KINGST	ON ROAD. I	EASTON. M	D 21601		
or Health I Hem 27	20e. Method of Disposition	20b. Place o	f Disposition (Name of			Oc. Location - City	or Town, Stete	
Pages nent of the int: If the	1 XBurial 2 Cremation 3 Remov	al from Stete	ry, crematory or other pl		3-16-99	FACTON	MD 21601	
Baitimore, emit. Pages 1 a epartment of Hea montant: If Nem: my Injury or othe	4 Donetion 5 Other (Specify)	SPRING	HILL CEMET		5-10-99	EASTON,	MD 21001	
Baitimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If frem 27 is marked other eny Injury or other traumatic event, page. To Be Co	21. Signeture of Funerel Service Licensee	TO CFSP	FELLOWS, H	ELFENBEIN				
Physician /Medical Examiner	b		consequence or):	nfarc	tion		l br	
A DO O O O O O O O O O O O O O O O O O O	Cause (Disease or Injury thet initiated events resulting in death) Last		consequence of):					
BOX leath ce attendia for use	Port II Other elgolilenst conditions continut	as to dooth but ast resulting h	a the underbine serves of	iven in Best t	22h Did toh	acco use contribu	ite to the cause of deat	
S, F.C. EO. ses that the deeth ce igned by the attend be detached for us by Physician/		ng to death but not resulting i	n the underlying cause g	iven in Pan t.	1 Tes		Probably 4 Unkno	
The law requires that have been signed in page 2 should be del					24a. Was en performe		b. Were autopsy findings available prior to completion of cause of death?	
The life he sage					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No	
				26. Place of Deet	h (Check only one))		
ystelen: The land of certificate he I director, page		ol: 1 ☐ Inpatient 2 DER/Ou	utpatient 3 DOA	ther	me 5 Residen		pecity)	
ang Phy Affer thi funeral		28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?				28d. Describe how injury occurred		
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	•	28f. Location (Stre City or Town,		Rural Route Number,	
To the Hospital or A within 24 hours eiter To the Funerel Direc completely filled in by Medical Certif		To the best of my knowledge in the basis of examination an and menner stated.						
within or the comp		2 5 . 1	29c. Licer	nse number	290	d. Date signed (Mo	onth, Day, Year)	
FSFO	DOLANDON &	Milliand	'und T	38990		8-17	-99	
	30. Neme and address of person who complete	ed cause of deeth (Item 23a)	(Type, Print)	10110		14	(/	
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State Registrar	Alig 1 3 19	99	1. Sp	rocks				

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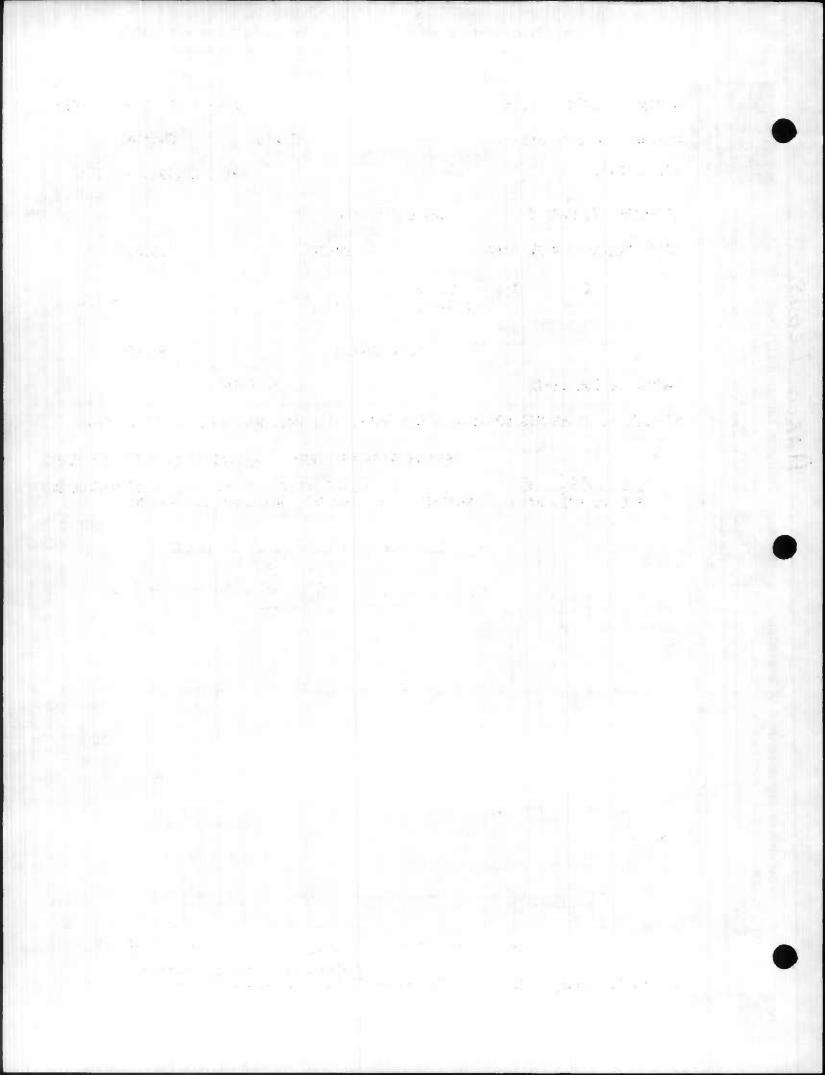
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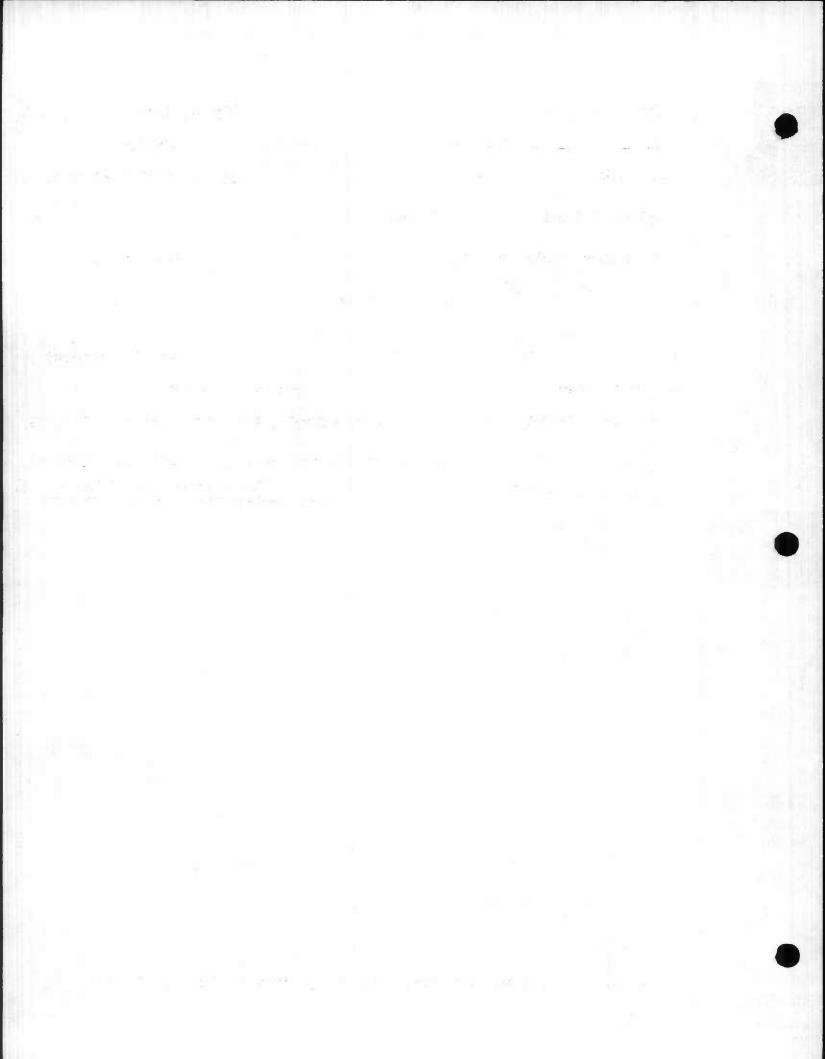
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edicai miner	4a Facility Name (If not institution, give street and number)						4b	o. City, Town, or Lo	ocation of Deeth	eeth 4c. County of Death		
	Civista Medical Center							LaPlata		Charles		
al or		9-5150	9X N 2□ F	Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months [Deys	Hours Min.	8. Dete of Bird (Month, Da APRIL 2	y, Year) 25,1915	9. Birthple Country VIRGII	ce (State or Foreign
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rec	10e. Street a					10f. Zip C	ode			10g. Citizen of V	Vhet Country	n
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by Fu		r Merried 2 Married	1 X Yes 2 If Yes, Give			☐ Yes 2[No X	Specify:		Specify	WHI	TF.
		wed 4 Divorced 15. Decedent's Ed	Yeer or Dates	1941	16a. Decede	nt's Usual (Occupat	tion	1	16b. Kind of Bu		
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		nt's Name/Reletionship (7		TN I A				nd Number or Rur				
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۵		ation 5 Other (Specify	•	RES	SURRECT I	Name end			/16/199	9 CLINTO	JN, MA	RYLAND
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an	shock,	or heert failure. List only o	one ceuse on eech	line.								nterval Between Onset end Deeth
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Ine	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of):											
edical Examiner	Sequentially list conditions, if any, leading to immediate											
ie E	Cause. Enter Underlying Cause (Disease or Injury											
		leath) Last		Due to (or es a consequ	ence of):					1	
M/u			d			_					1	
Physician/M	Part II. Other	significent conditions co	contributing to death but not resulting in the underlying cause given in Pert I.					n In Pert I.	23b. Dld	tobacco uas co	ntribute to t	he cause of death?
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by I												
De de									24a. Was perfo	en eutopsy ormed?	eval	a autopsy findings able prior to
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Be Completed by	25. Was case	e referred to medical	Magnitot				Pur					
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				State of Marylar		tificate of			Reg. No.	2	6866	
ı	Physici		1. Decedent's Neme (First, Middle, Last) Zoilus Joel LeMay,	Jr.				2. Date of Dea Month July 3:	Day	Yeer	3. Time of Death 8:00 A.M.	
	/Medic Examir		4e. Facility Neme (If not institution, give st				4b. City, Town, or Location of Death 4c. County of Death				O:UU A.M.	
4	Exami	101	11450 Asbury Circl	e. Apt. #320)		Solomons		Calve	rt		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	if Under 24 Hrs.	8. Dete of Birtl (Month, Day			lace (State or Foreign	
	Director		240-48-0042 Usual Residence of Decedent	^{M 2□ F} 66	Yrs.	Months Deys	Hours Min.	Aug. 29	9, 1932	Wash	ington, DC	
	and **		10a. Stete 10b. County	10c. Cit	ty, Town or Loca	ation				10	0d. Inside City Limits	
	Mary 1 sh	o	Maryland Calvert	ert Solomons							1 ☐ Yas 2 No	
	1 the	Director	10e. Street and Number			10f. Zip Code	1	10g. Citizen of W	/hat Coun	Ary?		
	3a o	0	11450 Asbury Circl	e. Apt. #320		20688		T	United S	teta	e	
	deeti	Funeral		2. Was Decedent Ever in U							an Indian,	
020	III Z I Z I S-UUZ be filed within 72 hours e al Hygiene. I other then "netural", o went, the Medical Exer	by Fu	1 Never Merried Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: Kore	es 2 No		an, Mexicen, Puerto Specify:	Ricen, etc.)	Black, White, etc. Specify: White			
Ö			15. Decedent's Educe		16a, Decede	ent's Usuai Occup	pation		16b. Kind of Bu			
215		piet	(Specify only highest grade Elementary/Secondery (0-12)	completed)	(Give ki	ind of work done O NOT use retire	during most of world)	ting	,		,	
217		E	12	College (1-4or 5+)	Printe	\mathbf{r}			Federal	al Government		
b		BeC	17. Fether's Name (First, Middle, Last)				18. Mother's Nem	e (First, Middle,				
<u>lai</u>		To	Zoilus J. LeMay				Frances	L. Pari	rish			
lan.			19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or 1									
2			Martha LeMay (wife	:)	11450	Asbury (Circle, A	pt. #320), Solom	ons,	MD 20688	
nore			20a. Method of Disposition Burial 2 Cremation 3 Red	movei from State	-	etory or other pla		Date	20c. Location			
₫			4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee			Neme end Addre	es of Facility				Maryland	
B	Ped of the grand o		1 to	7			L ern Maryl				lvert, P.A. MD 20736	
1	80	1	23a- Perf I. Enter the disease, or complice shock, or heart failure. List only one	thet caused the deat						,,,,,	Approximata Intervai Batween	
	Physician /Medicai Examiner		immediata Cause (Final disease or condition resulting in death)	Resp							Onset and Death	
	D #	Examiner		Cardin-	760	an	PAT					
	ficate be executed g physician and ss the burial-transit	am.	Sequentially list conditions,	Gadio-	or as a conseque	ence of):				1		
Ő,	e exe		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Demen	16-					į		
68760,	ate b hysic the b	edicai	that initiated avents resulting in death) Last		r es a conseque	enca of):				1		
	entific ling p	Me	d									
Вох	ttend or us	lan	4									
	the deeth cert y the ettending ached for use	Physician/M	Part tf. Other significant conditions contr	ibuting to death but not res	uiting in the unc	derlying cause gh	ven in Part f.	23b. Did to	obacco use con	tribute to	the cause of death?	
P.0	- D 2		COPD					101	res 2□ No	3 Prob	pably 42 Unknown	
ds,	8 99	d by	^	0				24a Was	an autonou	24h Wa	are autopsy findings	
ö		ete	Keanes	Pheomon	~			24a. Was a perfor	med?	eve	elieble prior to mpletion of cause	
of Vital Record	9 8 G	Completed							/	of c	death?	
<u></u>	Page 1							1□ Y	es 212 No	1 🗆	Yes 2000	
Z Z	Physician: The this certificate ral director, pag	Be	25. Was cese rafarred to medicel examiner?	spitai:		00	26. Piaca of Dea	th (Check only or	ne)			
ō	Phys this al dir	To	T Tes 2 F NO	1 □ Inpatient 2 □	ER/Outpatient	3□ DOA Oth	4 Li Nulsing N	ome 52 Rasid)	
	After funer	on	27. Manner of Deeth 1 ☑ Natural 5 ☐ Panding	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo		28d. Describe h	ow injury occurr	ed		
Sic	Attending r death. ector: Afte by the fune	cat	2 Accident Investigation 3 Suicide 6 Could not be		Yes 2 □ No	004	V		(D. A. M L.			
Division	offer death Director: / d in by the	Certification:	4 Homicide datarmined	et, factory, office		City or Tow	itreet and Numbern, Stata)	er or Hura	Houte Number,			
_	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral properties.	edical C	29a. Certifier 1 Certifying Physic (Check only 2 Medical Example	fan: To the best of my kno	wledge, daath o	occurred at the til	me, date and place,	and dua to tha c	causa(s) and ma	nner as st	ated.	
	To the H within 24 To the F complete	Medi	one)	and mannar stated.	GIOVOI IIIVO							
	T vit	-	29b. Signeture and little of certifier			29c. Licens	_	1	29d. Dete signed		Jey, Year)	
	/		7 200	MD		D50	0740		8/3/	97		
	15		30. Name end address of person who com Dhiren Shah, MD 11	plated ceuse of death (Item LO Hospital F			3. Prince	Freder	ick. MD	2067	'8	
	Sta	te	31. Date flied (Month, Day, Year)	32. Registrar's Signa			-,		,			
	Registr		AUG 0 3 1999	Geneva	4	don "	/ /					

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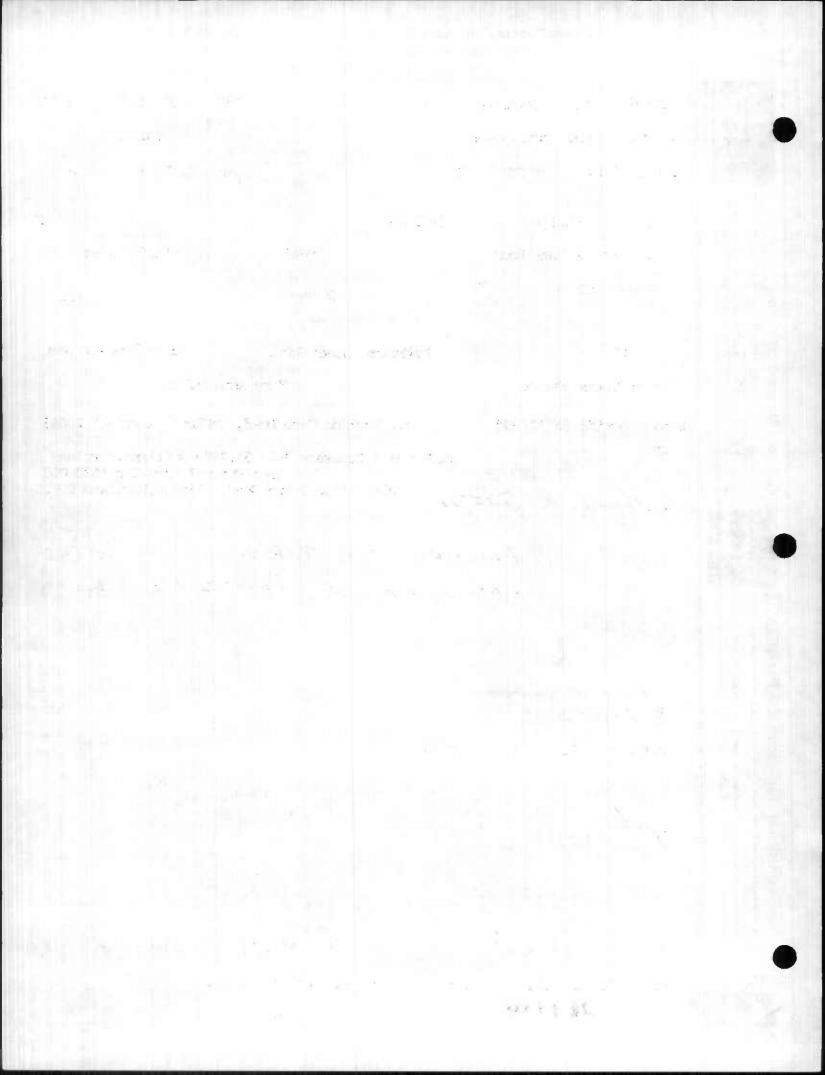


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) **Physician** July 1999 Jessie Lockwood 3:38PM W /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Health Care Center Charles LaPlata 8. Date of Birth (Month, Dev. Year) March 9, 1920 If Under 1 Year if Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 1 M XX F 79 Yrs. Georgia 250 12-7013 Director Usual Residence of Decedant the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic avent, the Medical Examinar must be morthed at 1 ☐ Yes 2 ☐ No Directo Charles MD LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 6363 Hawkins Gate Road 20646 United States death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Haalth and Mental Hygiena. Important: if Item 27 is marked other than any injury or other transmission. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yaer or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, etc. 1 Never Married Married 1 ☐ Yes 2 ☐ Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Federal Government Aviation Specialist 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Mary Anna Mulkey James Monroe Watson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6363 Hawkins Gate Road, LaPlata, Maryland 20646 Susan Sheriff (DAUGHTER) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBuriat 2 Cremation 3 Removal from State Cedar Hill Cemetery July 31,1999 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licenses Alexandria Ferry Road, Clinton, Maryland 20735 attel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tntervei Between Onset and Death **Physician** /Medical Immediate Ceuse (Fine) THRIVE . FAILURE disease or condition resulting in death) Examiner PANCREASE Examiner CARCINOMA death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of): USB BS detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown DIABTES PV Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed SEIZURE DISORDER completion of cause of death? page 2 s certificate has 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical axaminar?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospitel: Other: 4 Qursing Home 5 Residance 8 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of After Certification: Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 - Homicide 24 hours Certifying Physicfan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

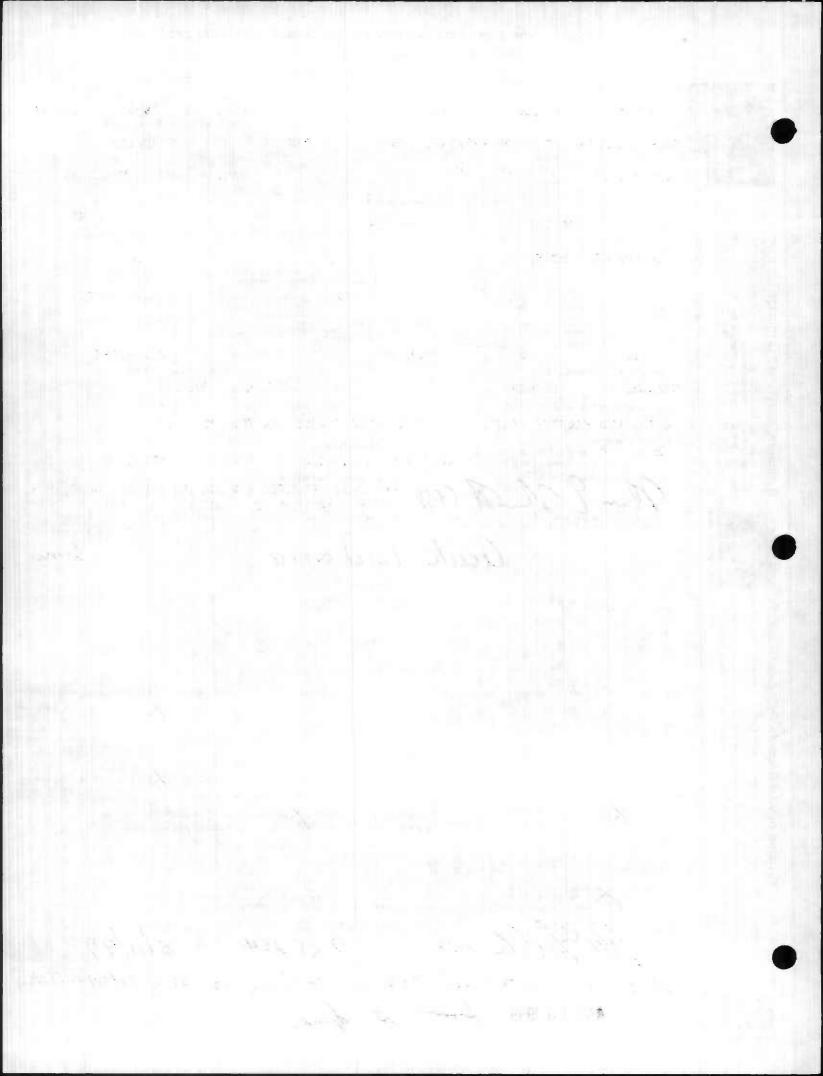
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a, Certifier completely (Check only one) To the ! within 2 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of certific 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) #6 Industrial Park Dr. 6B Waldorf, Md. Ashvin Patel, M.D. 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MORMANN 1999 FRANCES BARNES AUG. 11 4:46 AM /Medical 4b. City. Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner SHORE NURSING AND REHABILITATION CENTER DENTON CAROLINE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 TF 90 Yrs Director 215-07-8429 MAR. 26, 1909 MARYLAND Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at XIX Yes 2 No Director MD CAROLINE DENTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 420 COLONIAL DRIVE 21629 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Meritel Status 2 should be filed within 72 hours aftar n and Mental Hygiena. Is marked other than "naturel" or item 1 ☐ Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 No Specify: Specify: þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) DEPT. STORE CLERK other treumstic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) EASON CHARLES BARNES AMELIA Lo 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Haalth and Important: If item 27 Is in ELIZABETH BARNES/ SISTER 305 NORTH STREET, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 □ Cremetion 3 □ Removel from State 0 8-14-99 SPRING HILL CEMETERY EASTON, MD any Injury 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Septice Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Ch 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 6mes **Examiner** Due to (or as e consequence of) Examiner certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest physician and the burial-tran Due to (or es e consequence of): Box 68760 Physician/Medicai the Due to (or as a consequenca of) as USB Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 000 6 3 Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) luneral 28d Describe how injury occurred Certification: 27. Menger of Death 28b. Time of 28c. Injury at Work? Aftert Neturel or Attending 5 Pending investigation aftar death. 1 Tyes 2 No 2□ Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 4 | Homicide 24 hours Hospital Lartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. edicai 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 \$ 29b. Signature and the of centring 29d. Dete signed (Month, Dey, Year) S. Washington Steaston MD 469 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 32. Registra/s Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** August 13,1999 Johnny Makle 3:00 am /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Upper Marlboro Prince Georges 16611 Candy Hill Road If Under 1 Year If Under 24 Hrs. s. Date of Birth Months Days Hours Min. August 5. Social Security Number 6 Sex Funerai 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 15€M 2□ F Yrs. 69 Director 212-34-9794 Maryland 5,30 Usuel Residence of Decedent death with the Maryland 10a State show 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Madical Examiner must be notified at Director Upper Marlboro 1 X Yes 2 □ No Maryland Prince Georges 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 20772 U.S.A. Funeral 16611 Candy Hill Road Herris 11 Marital Status 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2√ No 1 Never Merried 2 Married ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates "naturaf", Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Carpenter Pyles Lumber Co. permit. Pages 1 and 2 should be file.
Department of Health end Mentel Hy
Important: If Item 27 is marked other
any Injury or other traumatic avera-17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be OL Maragret Fowler Rome Makle 19a. Informent's Neme/Reletionship (Type, Pnht) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Johnson/Sister16611 Candy Hill Rd, Upper Marlboro MD 20772 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Philips Ch. Cem Aug. 19,99 Aquasco MD 20608 uneral Service Ligarifie 21. Signature 22. Name end Address of Fecility 20608 Adams Funeral Home P.A.Aquasco MD 23e. Pert1. Ener the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or near failure. List only one cause on each line. Approximate tritervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) with Brain Metastasis /Medical Examine Examiner or Attending Physician: The lew requires that the death certificete be executed use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760. nding physician Physician/Medicai Due to (or es e consequence of) the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificate 1□ Yes 2 No 1 ☐ Yes 2 P No 25. Wes cese referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After this 27. Menner of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel s after death.

i Director: Aft
od in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

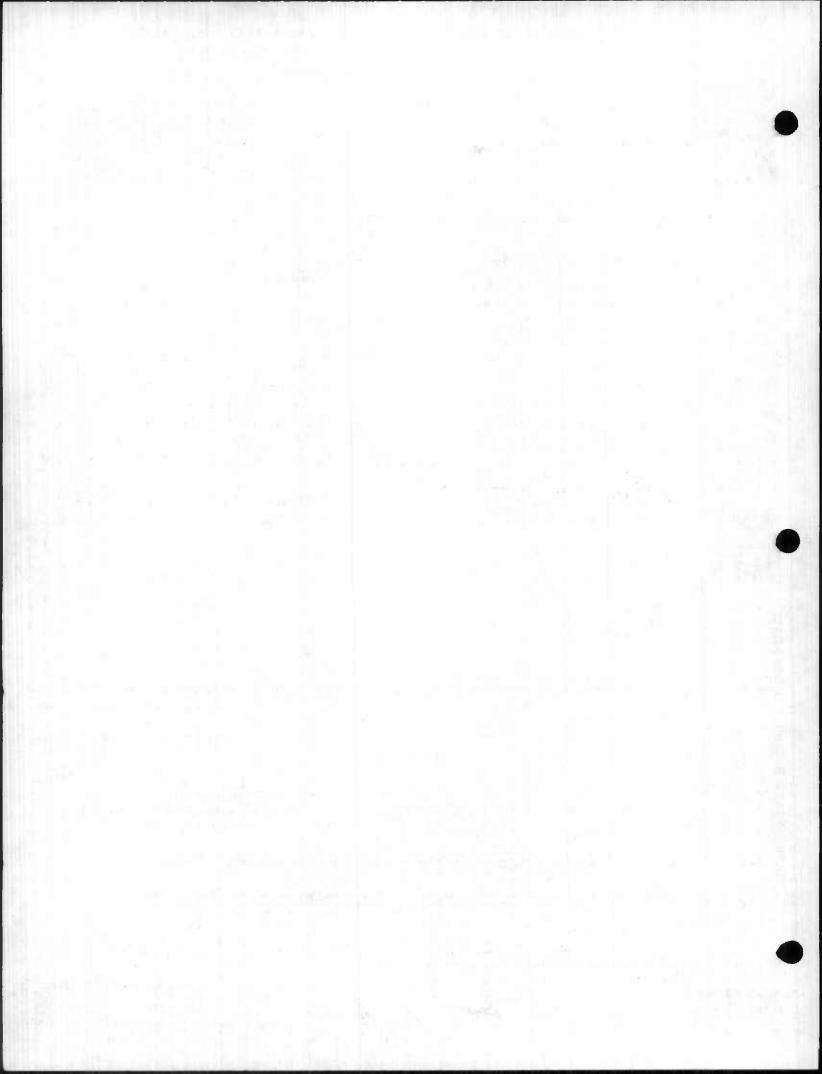
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner steted. Medical 29e. Certifler (Check only 29b. Signature and file of certified 29c. License number 29d. Dete signed (Month, Dey, Year) 38698 30. Name end address of person who completed ceuse ot deeth (Item 23e) (Type, Print) C# 201 11340 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

1999

AUG 17



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month Alice Lillian Meck 16, 0002 August 4s Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) 1 M 201 F Months Days Hours 214-26-3154 69 Yrs. Nov. 12,1929 Maryland Usuai Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Cecil Port Deposit Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 120 Linton Run Road 21904 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Lighthouse Christian Day Care 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Twelve Years Pleasant View Baptist Church College (1-4or 5+) Caregiver Port Deposit, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ralph Lynch Elizabeth Wiggens 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Donald Meck (Husband) 120 Linton Run Road, Port Deposit, Maryland 21904 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition Buriai 2 Cremation 3 Removat from State 8/19/99 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 22. Name end Address of Fecility 21. Signature of Funerei Service Licenses Lee A. Patterson & Son Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21903-0188 Approximate Intervei Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, If any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lesf Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findinga evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 100 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

27. Manner of Deeth

2 Accident

3 Suicide

29a. Certifier

29b. Signatu

4 Homicide

(Check only one)

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

them 27 is marked other than "natural", or itams 23s or 28s-f sho other traumstic evant, the Medical Example, must be notified as

Hygiene.

end Mental I

Department of Health Important: If item 27

any injury or

Peges 1 end 2

physician the 88 9SD the signed by

certificate has After this efter death. Diractor: Aft

or Attending Physician:

24 hours Hospital

within 2 To the To the

> 6 Registrar

31. Date filed (Month, Dey, Year)

28b. Time of

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes

2 No

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner es atated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

3195. Union Due

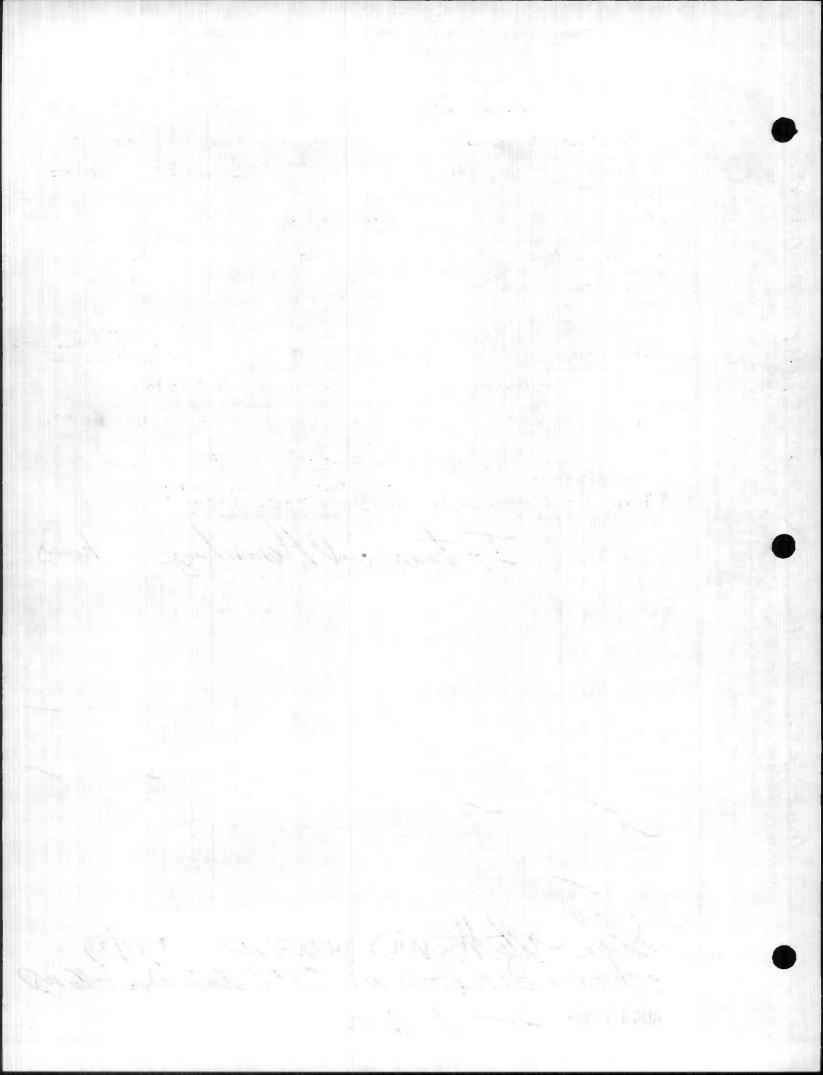
AUG 1

5 Pending

investigation

6 Could not be determined

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 2:44 P.M. Edward Franklin Mauk, Sr. August 10, 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical center Annapolis Anne Arundel If Under 24 Hrs. Hours Min. 8. Sex 1. M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Yrs 214-12-4613 88 Director June 4, Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. 1 ☐ Yes XXNo Directo Maryland Anne Arundel than "natural", or hama 23a or 28a-f the Medical Examiner must be notifie Galesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4844 Church Lane 20765 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 9th Hygiene. College (1-4or 5+) Carpenter Boat Building permit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy important: if New 27 is marked other any Injury or other transmissed other. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) 89 Albert S. Mauk Caroline Coughenour 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4844 Church Lane Galesville, MD 20765 Georgie Lee Mauk/ Wife 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1XXBurial 2 Cremetion 3 Removal from Stete Woodfield Cemetery 8-13-99 Galesville, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 21. Signatura of Funeral Service Licen 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset end Deeth **Physician** /Medical Sudden Cardiac Immediete Cause (Finel 30 minutes disease or condition resulting in death) Examiner Examiner that the death certificate be assecuted physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence d) Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ardiac dyskyllnia with 3 Probably 4 Unknown 1 Yes 2 No signed b by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 30 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Mennar of Death 1 Naturel 2 ☐ Accidant 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year, 134 owensville Rd West River MD Kae. Hoeroui

State Registrar 32. Registrar's/Signature

2 1999

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death August 9, **Physician** Julia A. Majerowicz 15:34 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel B Under 24 Hrs. B. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 210 F 217-26-7641 69 Director Jan 2, 1930 Maryland Usual Residence of Decedent the Maryland 10x State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Pasadena 1 Yes 22 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be 716 Pasadena Road 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: Specity: White à 3 Wildowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working We. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Department of Elementary/Secondary (0-12) College (1-4or 5+) Personnel Administrator Transportation 12 Pages 1 and 2 should be filed w timent of Health and Mental Hygler Sant: If New 27 is marked other th jury or other traumatic event, Illy 17. Father's Name (First, Middle, Last) Walter Kaminski 18. Mother's Name (First, Middle, Maiden Surname) Rose Wolak Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Majerowicz/Son 716 Pasadena Road Pasadena, MD 21122 Date 12 20a. Method of Disposition 20b. Place of Disposition (Name of cornetery, crematory or other place) 20c. Location - City or Town, State Meadowridge Memorial 1999 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation_5 ☐ Other (Specify) Department of Important: If any Injury or anse. Elkridge, MD 21. Signature of Fureral Service Mar 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician ongestive Heart Foilure /Medical Cause (Final 2 years Examiner Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be ass Box 68760, Physician/Medical Pag. Due to (or as a consequence of) 1 requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□Yes 2 No 3 Probebly 4 ☐ Unknown of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 2 N No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) Certification: To 1 Yes \$8 No 100 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Affec Division Athending 5 Pending 2 Accident 1□Yes 2□No after death 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) B 4 Homicide à To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed can ee of death (Item 23a) (Type, Print) Agrahad Rd. Glen Burne 40 21061 (5008a/2 asp.

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

AUG 1 2 1999

32 Registrar's Signature

Physic /Med Exam

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0020

> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit

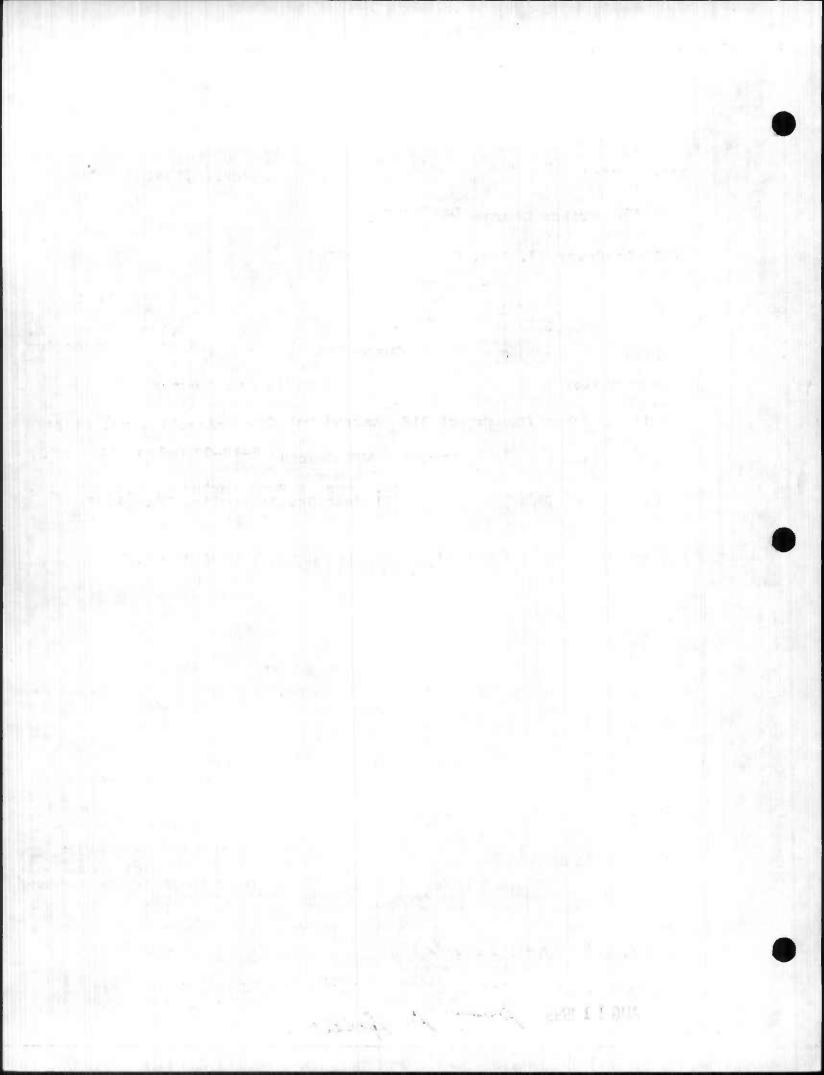
Division of Vital Records, P.O. Box 68760.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		C	ertificate o	f Death			leg. No.	J 6-	6873										
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Izel Medley	[r					Month	Day	Year											
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5. Social Security Number 6. Sex			(ay) If Under 1 Ye		24 Hrs.	8. Data of Birth	1												
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Maryland Prince		city, Town of						1	1 Vas 2 ☐										
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State Registrar

Stephen S. 12 31. Date fied (Month, Day, Year) AUG 1 1 1999 Radentz



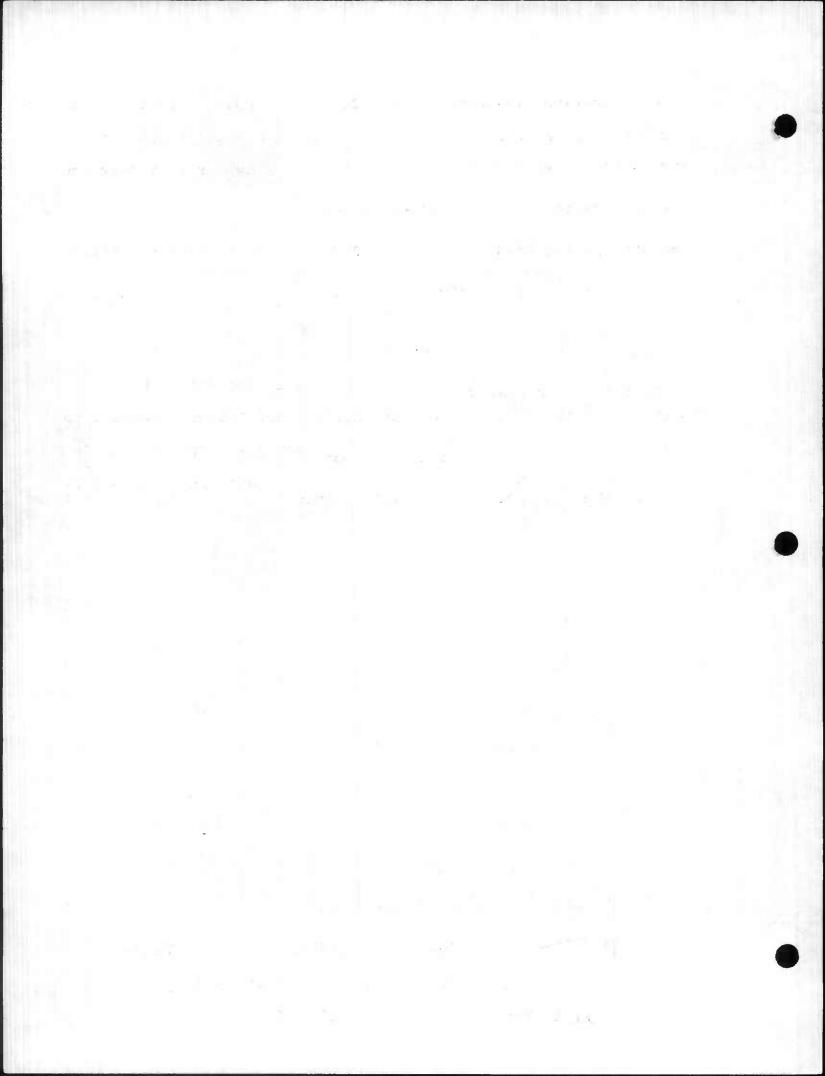
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** John Charles Cleveland Mister, Sr. Day 9 9 Year Jump 25 1:15 AM /Medical 4a. Facility Nama (If not institution, give street and number)
Box 350 Adelina Road 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert 7. Aga (In yrs. last birthday)
67

Wonths Days Hours Min. Se Moeth, Day, Year 31 5. Social Security Number 213 34 5514 9. Birthplaca (Stata or Foraign **Funeral** MM 20 F Maryland Director Usual Rasidence of Dacedant 10c. City, Town or Location
Prince Frederick 10a. Stata Maryland Calvert show 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f short traumstic event, the Movice. Examiner must be notified at 1 Yas 2 No Director 10e. Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? Box 350 Adelina Road 20678 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Biack, White, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. And the Manual in the Manual in the Manual in or die with the Wester the Wester the Manual event, the Medical Experimenty or other the 1 ⊠ Yas 2 □ No4 9 - 58 If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ Xio Specify: SpecifyWhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) waterman seafood 10 17. Fathar's Nama (First, Middla, Last) 16. Mothar's Nama (First, Middla, Maidan Sumama) Burdette Ruth Skur John Franklin Mister 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 350 Adelina Rd. Prince Frederick MD 20678 19a. Informant's Name/Ralationship (Type, Print)
Orena V Mister- wii Lorena 20b. Place of Disposition (Nama of camatary, cramatory or other place) July 28, 1999 Dunkirk Maryland Southern Memorial Gardens 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata permit. Page Department o Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility Rausch Funeral Home PA 21. Signature of Funaral Sarvice Licenses 4405 Broomes Island Rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medicai Concer 1891 Examiner Examiner physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in daath) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 DYes 2 No 3 Probably 4 Unknown ģ The law requires 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Be Completed page 2 s 2 No 1 Yas 1 Yas 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. director. 25. Was casa rafarred to medical 26. Place of Death (Check only ons) Other: 4 Nursing Homa 5 Nasidance 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 26b. Tima of 28c. Injury at Work? 26d. Dascribe how Injury occurred After 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accident Director: / 6 Could not be detarmined 26f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicida 26a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hos To the Funer completely fil Medical 29a. Certifier (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D46314 MO 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Powl V Pomilla, M.D. Prince Frederick 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State

Registrar

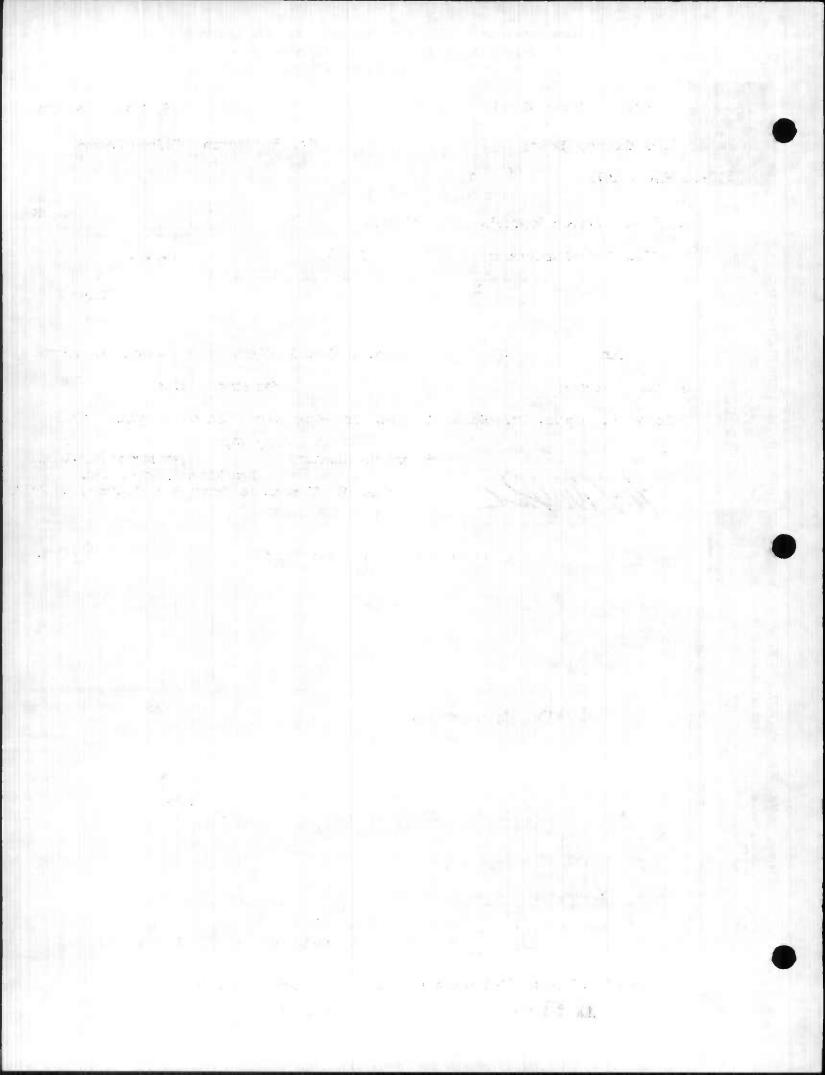


20 State 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Suresh Patel, M.D. 7501 Surratts Rd. # 307 Clinton, Md. 20735 31. Dete filed (Month, Dey, Year) 2 6 1999 32. Registray's Signeture

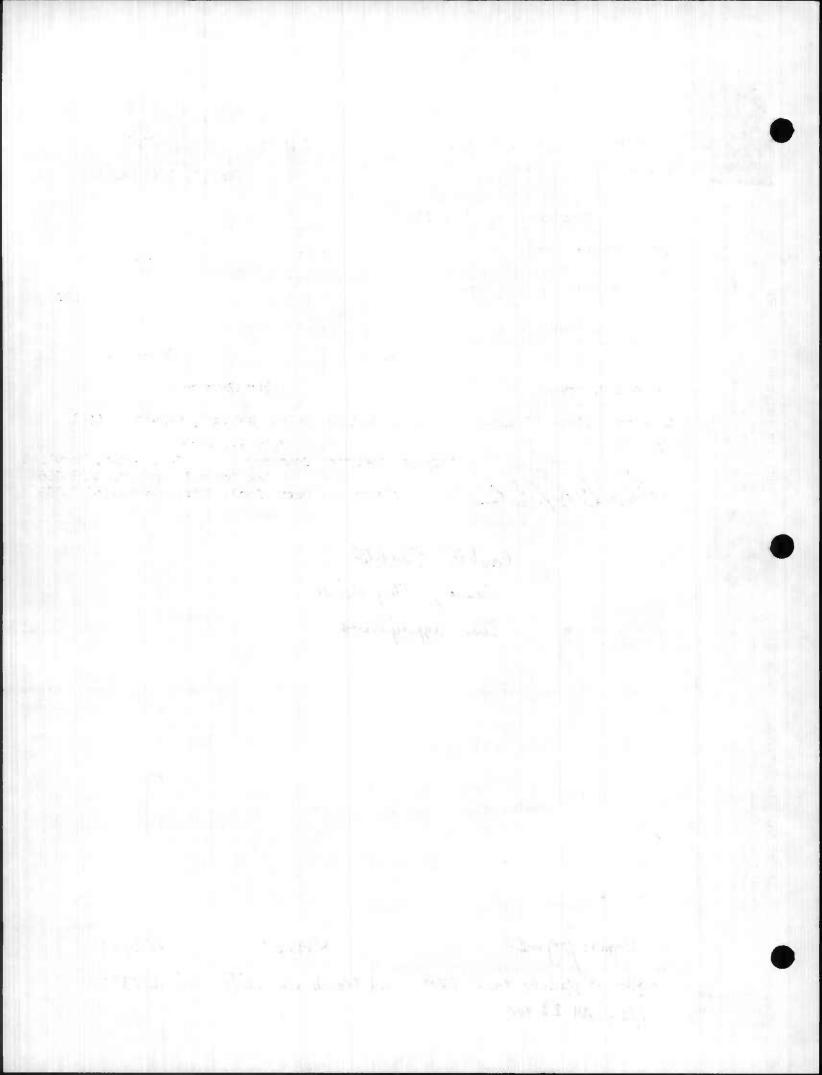
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Registrar



State of Maryland / Department of Health and Mental Hygiene

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Examiner must be notified at by Funeral Director		Street end Number 013 Nichol	as Ro	ad			10f. Zi	20601		10g. Citizen of V United	Whet Country? States			
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any injury	21. 5	21. Signeture of Funeral Survice Licenses 22. Name end Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735												
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Be		ves case referred to m	nedical					26. Place of De	eeth (Chack only	one)	1			
2	27. M	examiner? Hospitel: Other			28c. Injury at Work?	ng Home 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred								
ō	1	Sulcide 6 0	nvastigation Could not be determined	De Sha Blace of Injury At home form street feeten, office				28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
ertification	4										enner es stated.			
edical Certification:	29a.		ertifying Phy dical Exam	ysician: To the best of niner: On the basis of end menner ste	exemine	tion end/or Inv	restigetlo	, In my opinion, deeth occ	curred et the time,	dete and plece,	and due to the cause(s)			
Medical Certification	29a.	(Check only 2 Me	dicai Exam	liner: On the basis of	exemine	tion end/or inv		c. Licensa number	curred et the time,	dete and plece,	and due to the cause(s) d (Month, Dey, Year)			
edicai	29a.	(Check only 2 Me	ertifier	liner: On the basis of	exemine	tion end/or Inv		c. Licensa number	curred et the time,	dete and plece,	and due to the cause(s)			
edicai	29a. 29b.	(Check only 2 Me	ertifier	iner: On the basis of end menner ste	exemine ted.	tion end/or Inv	29 Print)	c. Licensa number	clintom A	dete and piece, 29d. Dete signe 7/2	and due to the cause(s) d (Month, Dey, Year)			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUTY 30, Day 999 Year John Wesley Meredith 6:26 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Owings
If Under 1 Year | If Under 24 Hra. 6350 Dant Drive Calvert 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 18 M 2 F Months Days Hours Yrs. Director 218-54-7302 Sept. 30, 1948 Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limita 28a-f show event, the Medical Examiner must be notified at 1 Yes 28 No Director Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Herns 23a 6350 Dant Drive 20736 Funeral United States death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Datea: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced "natural". White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, in a Media ones. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Commerical Building 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be George Lockett Meredith Virginia Dell Rudy 19a. Informant'a Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Arlyn Meredith (wife) 6350 Dant Drive, Owings, Maryland 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July 31, 1999 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. colon cancer with liver metastasis **Physician** 2 MOITS /Medical Immediate Ceuse (Finai disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use es the buriel-tran Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) P.O. 1 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records. by cate has been sig. 24b. Were autopay findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred Division After 5 Pending Investigation 1 Naturai To the Hospital or Attendin within 24 hours after death.
To the Funersi Director: Af completely filled in by the fu 1 Yes 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of cartifier G. 29d. Date signed (Month, Day, Year) Julies. UM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Su. 116, Prince French and 20678

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dey, Year)

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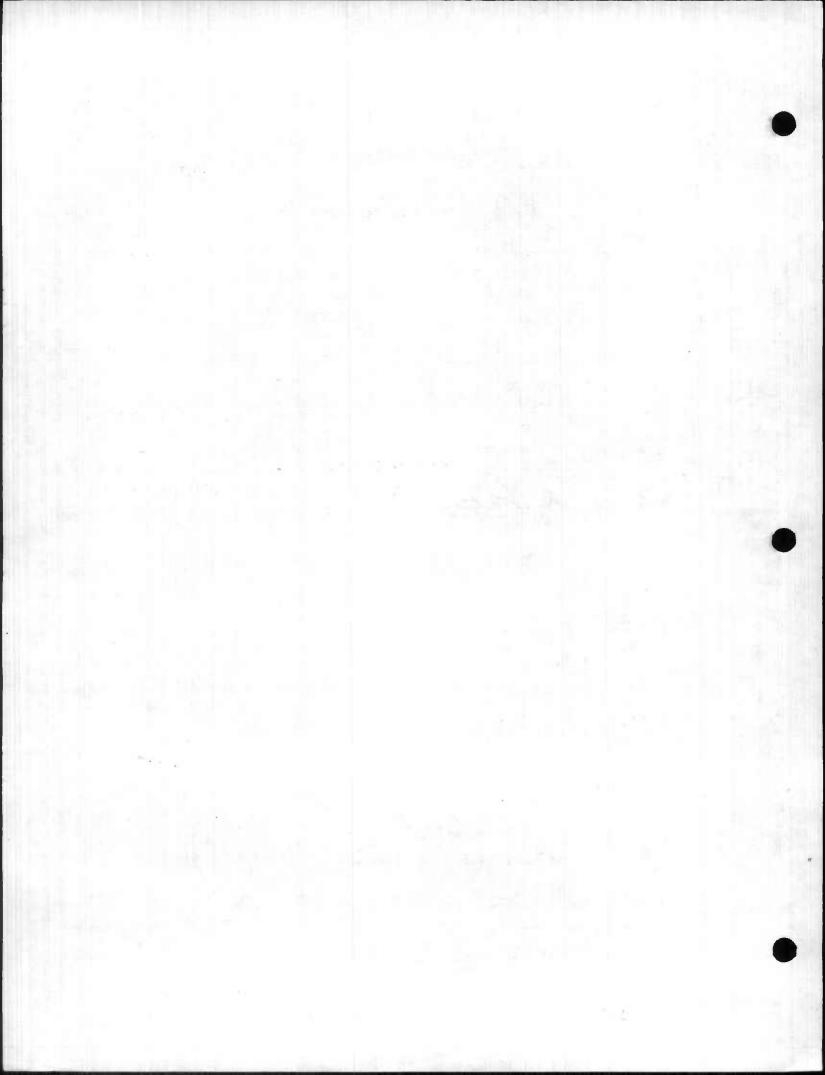
32. Registrer'a Signature

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State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate c	of Death	7		Reg. No.	2 1	400/6
	1. Decedent's Nama (First, Mid	dia, Last)	38.371					2. Data of De		Made	3. Tima of Death
Physician	Larry				Month July	29 1999		08:15 PM.			
/Medical Examiner	4a Facility Nama (If not instituti	on, giva street and no				4b. City, To	own, or Lo	cation of Deat			300123 2111
Examine	3	132 Brink	ley Road	1 #304		Tem	ple I	Hills	Prin	ce Ge	eorge"s
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye			8. Data of Bir	th		place (Stata or Foreign
Director	055-42-7437	112M 2□ F	47	Yrs.	Months Da	ys Hours	Min.	July 2	0,1952		x, N.Y.
9	Usual Residence of Decedent										
Te ta	10a. Stata 10b. Coun			y, Town or Lo						1	Od. Insida City Limits
r hams 23a or 28a-f sho ninar must be notified at Funeral Director	MD P.G. Camp Springs									-	1 □ Yas 2XX40
	10e. Street and Number				10f. Zip Cod	le			10g. Citizen of	What Cour	ntry?
	3132 Brink		2074	8			United States				
The line	11. Marital Status	,S. 13. \	Was Decedent	of Hispanic Or	rigin? (Spe	cify Yas or No	No- 14. Race - American Indian, Black, Whita, atc.				
> 25 Hz	1 Nevar Married 2 Ma		1 Yas 2 1			, mount alony					
Exa.	3 Widowed 4 Divorce	d Year or I	2 □ No ive Dates:		X	X			Specil	Bla	ck
other than 'nature event, the Medical. Be Completed		nt's Education est grada completed,)	16a. Deced	ient's Usual Oc kind of work do	cupation ne durina mos	st of worki	na	16b. Kind of B	lusinass/Inc	dustry
and Ide	Elementary/Secondary (0-12)		(1-4or 5+)	lifa. I	DO NOT use re	tired)					
Cor Br				Mail	Handel	_					Service
even Be	17. Father's Nama (First, Middle							na (First, Middla, Maidan Sumama)			
To Be	Harry A . Mac	ckey, Sr.		1.00		ola J	ames	S			
traum traum	19a. Informant's Name/Relation Pablita Macket					al Routa Number, City or Town, Stata, Zip Code) Camp Springs, Maryland 2(
e de	20a. Mathod of Disposition	ey (wife)			sition (Nama o		1	Data	20c. Location	- City or To	own, Stata
10	1 Burial 2 Cremation		Stata		natory or other		A	ug 5th	-		
nlan	4 □ Donation 5 □ Other (21. Signature of Funaral Service		Cai	lvertor	Nation	nal Cen	n. 1	999	Calvert	on I	Vew York 6633 Old
my my	21. Signature of Punaral Service	Cicerisee	1	Δ.	l exandr	ia Fem	rv Ro	ad. Cl	inton M	arvla	nd 20735
	23a. Part1. Entar tha disease,	R.D.	attel								
dedical aminer	Immediata Causa (Final diseasa or condition rasulting in death)	. Hyp	Due to (c	ive or as a conseq	Cardi	ovasc	ular	Dis	ease	1	
s the burial-transit	Sequentially list conditions, if any, leading to immadiata cause. Entart Inderlying Cause (Disease or injury c.										
as the bu	Cause (Disease or injury that initiated events resulting in death) Last										
d by the attending presented for use as the state of the	Does II Other also Miles at an Miles at a state to the state of the st										
signed by the atte d be detached for d by Physicia	Part II. Other significant condit	Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I.								10	o the cause of death?
deta deta								1 Yea 2 No 3 Probably 4 U			bably 4 ☐ Unknow
signe d be d								24a Was	an autopsy	Zah W	ara autopsy findings
should should leted								perfe	ormed?	av	allable prior to implation of causa
								Lin	nited	of	death?
certificate has rector, page 2 Be Comp								1/2	Yas 2 No	1,5	Yas 2□ No
s certific director,	25. Was casa refarred to medic axaminer?					- 1	a of Death	(Check only	one)		
0 D	1 X Yas 2 □ No			ER/Outpatien	1 3LI DOA		ursing Ho	ma 5 Resi	dence 6 Ot	har (Specif	y)
or: After thi the funeral cation: T	27. Manner of Death 1 Natural 5 ☐ Pend	ing 28a. Data	of Injury oth, Day Year)	28b. Time of Injury		njury at Nork?		28d. Dascribe	how injury occu	rred	
y the fu	2 Accident inves	tigation			M	Yas 2					
al Director: After tied in by the funeri Certification:		mined 286. Place	e of Injury - At he ling, etc. <i>(Specif</i>						Street and Num wn, State)	ber or Rura	al Routa Number,
To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 ☐ Certify	ing Physician: To the	best of my kno	wledge, death	occurred at the	e tima, data ar	nd place, a	and dua to tha	causa(s) and m	annar as s	tated.
To the Funeral Director: completely filled in by the Medical Certifical	(Check only one) 27 Medica	Examiner: On the band mar	pasis of axamina nner stated.	tion and/or inv	restigation, in m	y opinion, dea	ath occurr	ed at tha tima,	data and place,	, and dua to	o tha cause(s)
Toth	29b. Signatura and little of certifi	er	4		29c. Lic	ense number			29d. Data signi	ed (Month,	Day, Year)
	11-11	1 1/	Tac	12,	un c	.C.M.E			77	** 20	1000
16	30. Nama and addrass of person	n who completed cau	se of death (Item	25a) (Type.		·· C.P.E	•		JUL	y 1U,	1999
Ч	Strohen <	Rade	177			pet P	altin	norea M	aryland	2120	1
State	31. Dala filed (Month, Day, Year		Registrar's Signa	itura /	/	CCL, D	ULLIII	MIE, M	err A TGIN		1
Registrar	AUG 0 3	1999	Seneva	Ø.	000	the					

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Please	Type or F State of		nd / D	epartm	ent of			II Copies Mental Hy	giene	^	26879
Decedent's Name (First, Middle, La.	et)			Jeruno	ale U	Dealli		2. Date of D	Reg. No.		3. Tim
JOHANNA	51)			MAC	KAL	г		Month JULY		999	22:53
				MAC	NAL.		!				
ta. Facility Name (If not institution, giv Calvert Memoria								ocation of Deal ederick		calve	
5. Social Security Number 213-22-1348 6. S	ax 7 □ M 2☐XF		(In yrs. last birthdey) If Under 1 Yaar 85 Yrs. Months Days				24 Hrs. Min.	8. Data of Bi (Month, D. March	8. Data of Birth March 5, 1914 9. Birthplaca (State or Fo Country) Maryland		
Usual Residence of Decedent 10a. State 10b. County		140. 0									
Oa. State 10b. County Maryland Calve	rt	10¢. Ci	ity, Town	or Location	ler1a	and					10d. Inside City Limit
Oe. Street and Number					Zip Code				10- 04	4) 4 m = 4 C =	
	T.1	. 1 D	. 1	101.					10g. Citizen		untry?
6975 Old Solom					2078					ISA	
1. Marital Status	12. Was Deced Armed Ford	es?	J,S.	13. Was De	pecify C	of Hispanic Ori uban, Mexicai	gin? (Sp n, Puarto	pecify Yas or No Rican, etc.)		ace - Amei iack, White	rican Indian, e, etc.
1 ☐ Never Married 2 Ă Married 3 ☐ Widowad 4 ☐ Divorced	1 ☐ Yes 2 If Yas, Giva Year or Dat				2 ZN				Spe	D.1	Lack
15. Decedent's Ed	15. Decedent's Education (Specify only highest grade completed)				Isual Occ	cupation	t of word	kina	16b. Kind of	Business/	Industry
Elementary/Secondary (0-12)	or 5+)	1 9	(Giva kind of work done during most of working life. DO NOT use retired) Farmer Farming								
7. Father's Name (First, Middle, Last)				arme	_	er's Nam	na (First, Middle	1	ming		
Harvey	Car	10			011						
19a. Informant's Name/Reletionship (7	Time Printl	Cal		Mailing Adds	ooo (Ctro			ral Davida Mumb		nown)	
Alice Height/Gra		er		O. Bo				rel Route Numb		ni, Siare, Z	up code)
Oa. Method of Disposition	daaabiii			Disposition (. 7	OWII	Data	20c. Locatio	n Chuas	Town State
1 Burial 2 Cramation 3 □ 4 Donation 5 Other (Specify	Removal from SI	ete	cam etery,	Rock C	or other p Thur c	h Cem.		/3/99	Port F	epub1	ic, MD
21. Signatura of Funeral Service Lican Deschipe G.	Sewe	ee						vell Funda. Prince			k, MD 20678
23a. Part1. Enter the disease, or comp shock, or haart failure. List only	olications that car ona causa on eac	sed the deat th line.	th. Do no	t enter the n	node of d	tying, such as	cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	. Car	diac	ec Anvest De to (or as a consequence of):						1		
	b. Dia	hetes	Mi	ellit	ان.						
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury		Due to (d	orasa co	nsequenca	of):					į	
Cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (c	due to (or as a consequence of):								
	d									1	
Part II. Other significant conditions or	ontributing to dea	h but not res	sulting in t	he undariyin	g causa	given In Part I			tobacco use		to the cause of death
									an autopsy		Were autopsy findings
								10		C	completion of causa of death?
5 Was race referred to medica!						00.00			/\		Yes 2 No
5. Was casa referred to medical axaminar?	Hospitel:					Other:		th (Check only			
1 ☐ Yes 2 No 7. Manner of Death	1 ☐ Ing		ER/Outp		DOA	4 LINU	irsing Ho	ome 5 Res		other (Spec	cify)
1 Natural 5 Pending 2 Accidant invastigation	(Month,	Dey Year)	28b. Tin		28c. In W	ijuryaτ Vork? □Yes 2□	No	28d. Describe	now injury occ	urred	
	he					28f. Location (Straet end Number or Rurel Routa Number, City or Town, Stete)					

Examiner signed by the attending physician and d be detached for use as the burial-fransit The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, should I paga 2 hes

To the Hospital or Attending Physician: The within 24 hours after death. To the Funstal Director: After this carifficate is completely filled in by the funeral director, pag

29b, Signature and titla of cartifier

JULIE

31. Date filed (Month, Day, Year)

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

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Certification: To

Medicai

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Director

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ehow any highry or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Baltimore, Maryland 21215-0020

29c. Licanse number D52192

29d. Date signed (Month, Dey, Year)

31 1999

d diving the completed cause of death (Item 23a) (Type, Print)

20678

State Registrar

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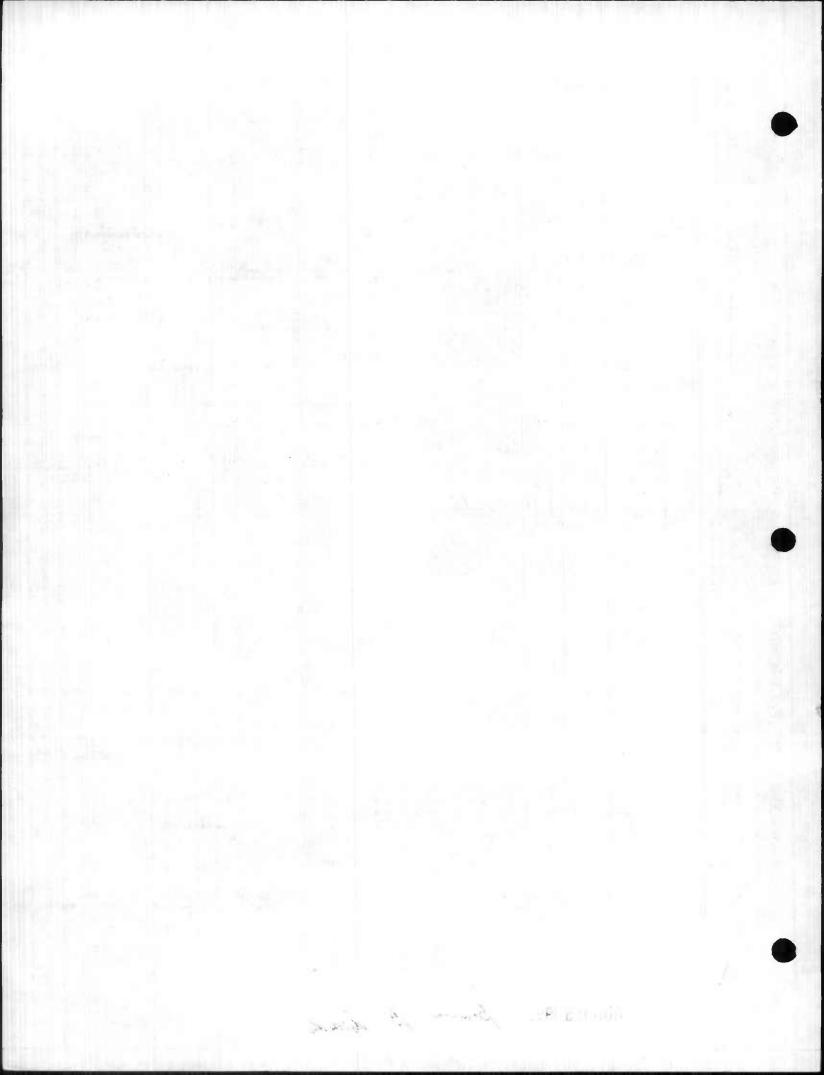
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State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	of Death		Red. No.	2688	0
		1. Decedent's Nam	e (First, Middle, La	ist)			8.1		2. Date of D	eath	3. Time of I	Death
Physici		Walter					Maddo	ox, Sr.	Month August	Dey 1999	Year 10:00	ΔM
/Medic Examin	-			ve street and numbe	r)		Liada		or Location of Dea			7 77 7
		Salish	urv Cente	er: Genesi	s Elde	enCare		Salisbu	rv. MD	Wicomi	CO	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date						Hrs. 8. Date of B.	irth	Birthplace (State or Country)	Foreign		
Director		218-30-1 Usual Residence o	187	1 🖾 M 2 🗆 F	78	Yrs.	WOINTS	Days Hours	Aug. 2	8, 1920	Maryland	
/and		10a. State	10b. County		10c. City	Town or Loc	cation				10d. Inside City	y Limits
Men H	to	Maryland	Wicomico		Sa	lisbur	V				1 Yes	2 □ No
r 28	Te C	10e. Street and Number 10l. Zip Code								10g. Citizen of W	fhat Country?	
17 wit	a D	222 Haze	1 Avenue					21801		USA		
90	Funeral Director	11. Marital Status		12. Was Deceder Armed Forces	t Ever in U,S	3. 13. V	Vas Deceder	nt of Hispanic Origin y Cuban, Mexican, P	? (Specify Yes or N		- American Indian, k, White, etc.	
by W.	by Fu	1 Never Marr 3 Widowed	led 2 Married 4 Divorced	1 Yes 2 H	XNo		1 ☐ Yes 2 🖾 No Specify:			Specify	1.00	
21215-0020 d within 72 hours af jiene. Then "natural", or the management	P		15. Decedent's E			16a. Deced	Decedent's Usual Occupation			16b. Kind of Bu	siness/Industry	
	Completed	(Spec	ondary (0-12)	ade completed) College (1-4o	(5+)	(Give I	kind of work O NOT use	done during most of retired)	working			
d withir glene.	mo:	12th	indary (0-12)	College (1-40)	34)	labor	er			Deer's He		Ctr.
be filed tal Hygied d other event, tr	Be	17. Father's Name	(First, Middle, Last)	PERM			18. Mother's	Neme (First, Middle	e, Maiden Sumam	e)	
	10	George W	 Maddox 					Nac	mi Collin	าร		
aryla 2 should end Mer a marks	•	19a. Intormant's N	ame/Relationship	Type, Print)		19b. Meilin	g Address (Street and Number o	r Rural Route Num	ber, City or Town,	State, Zip Code)	
and 2 parth 127 l		Margaret Maddox/wife 222 Hazel Avenue - Salisbury, Marylan								d 21801		
Baltimore, semit. Pages 1 a Department of Nes mportant: if them my injury or othe ans.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)							20c. Location -	City or Town, State		
Pages nant of any or o			5 Other (Special		Samu	iel We	slev (Church Cem	8/07/99	Manokin	, Maryland	
S interest		21. Signature of Fu	neral Service Lice	nsee	Journe	22.	Name and	Address of Fecility	1213 Jers	ey Road	- Salisbury	У,
00 88558		171		/ Ah	1100	2		Memorial			MD 2180	
		23a. Part 1. Enter t	he disease, or com	offications that cause	ed the death	Do not ente	or the mode	of dying, such as cer	diac or respiratory	arrest,	Approximate	
Physician		snock, or nea	rt tallure. List only	one cause on each	1						Onset and D	
/Medical		Immediate Cause disease or condition	(Final	Poven	monks	-					of weeks	
Examiner		resulting in death)		a. I.		as a consequ	uence ot):			1		
n &	ner			Debil	traine	2 Com	elilion	~ 2° 70	Zema 1	esslive		
cuted	am	Sequentially list co	nditions.	b	Due to (or	as a consequ	uence of):					
o e la la la la la la la la la la la la la	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Cause (Disease or Injury Cause)									e t	
68760, ifficate be executed g physician and as the bunel-transit	edical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):									t	
E 014	¥ 1	,										
Both cer attendin for use	an			d								
I HECOrds, P.O. BOX The law requires that the death cent are has been signed by the attendin page 2 should be detached for use	Completed by Physician/N	Part II. Other signif	icant conditions	contributing to death	but not resul	ting In the un	derlying cau	ise given in Part I.	23b. Die	23b. Did tobacco use contribute to the cause of deeth?		
P.O. hat the de detached detached	P.	5.0	CASS						1	Yes 2□ No	3 Probably 4□t	Jnknown
S the state of the	by	270-	C p/1 ce									
Kecords, he law requires the has been signed age 2 should be to	B	Bico	25 /	WA						s an autopsy lomed?	24b. Were autopsy tii available prior to)
2 8 6	De la								-		completion of ca of death?	10.949
	5	Wr.	DDM						10	Yes 2 No	1 ☐ Yes 2 🗹 1	No
VITAL I	Be	25. Was case refer examiner?	red to medical						Deeth (Check only	one)		
nis ce I dire	၉	1 ☐ Yes 2 월	No	Hospital: 1 ☐ Inpat	tient 2 E	R/Outpatient	3□ DOA	Other: 4 Nursi	ng Home 5 ☐ Res	sidence 6 🗆 Othe	er (Specify)	
D O P P P P P P P P P P P P P P P P P P		27. Manner of Deat	h 5 Pending	28a. Date of In (Month, D	jury lay Year)	28b. Time of Injury	280	c. Injury at Work?	28d. Describe	how injury occurr	ed	
ondir Ar: Ar	atk	2 Accident	investigatio				М	1 ☐ Yes 2 ☐ No				
DIVISION OF or Attending Physical death. Orector: After this in by the funeral di	¥	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. Place of I	njury - At hor	ne, farm, stre	et, factory,	office		(Street and Numb own, State)	er or Rural Route Numb	her,
D of D of	Certification:											
DIVISION Of VITAL HV To the Mospital or Attending Physician: The I within 24 burst sider death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only						the time, date and p			nner as stated. and due to the cause(s)	
the F the F		one)		and manner s					The state of the s			
To Veit	Σ	29b. Signature and	title of certifier				29c. l	License number	. 7	29d. Date signed	(Month, Day, Year)	
		1	Much					1990	13	010	1199	
N		30. Name and addr	ess of person who	completed cause of	death (Item	23a) 7Type, F	Print)	2 53	elis m	0 - 10	2-10	TOTAL
		Min	1Kins	1104	werse	th an	3/1	me Sy	Kis M	000	Jag	
Sta Registra	_	31. Date tiled (Mon	In, Day, Year) AUG 0.5.1		trar's Signati	ITO L						

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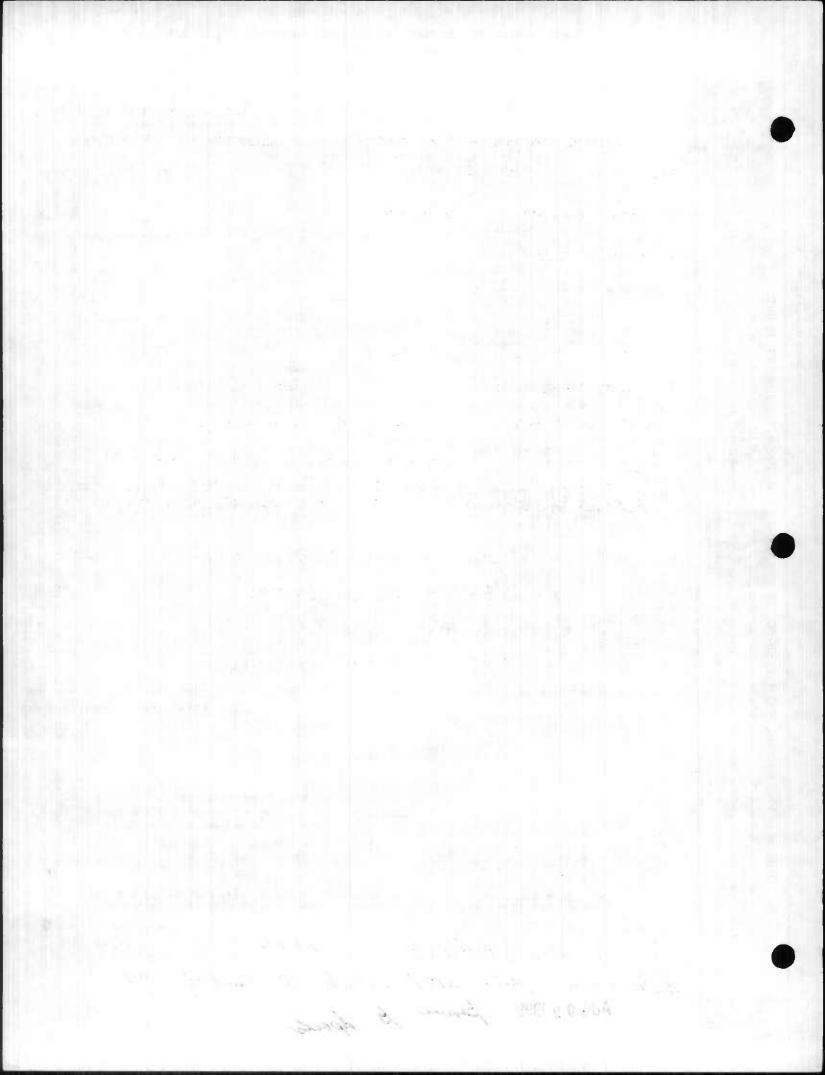


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MENNE august 6 1999 1223 SARA VIRGINIA /Medical 4b. City, Town, or Location & Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 X F 88 Yrs. 214-10-6067 April 26,1911 Director Maryland Usual Residence of Deceden 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Wicomico Salisbury Maryland 1 ☐ Yes 2X No Director r 28a-f a notified 94 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23s or event, the Medical Examiner must be r 21801 USA 28706 Ocean Gateway Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa ratired) Elamentary/Secondary (0-12) College (1-4or 5+) County Government Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) h and Mental I 1 and 2 should be John Henry Dulany Williams Lillie E. Hilghman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Virginia Perdue/Daughter Health Hem 27 I 721 Camden Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If It 1 DI Burial 2 Cremation 3 D Removal from State à 8/10/99 Hebron, MD Springhill Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) MOIOS 22. Name and Addrass of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licanses aviel 501 Snow Hill Rd., Salisbury, MD 21804 Warmana 1 23a. Parti. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical nullers Examiner Examiner Mas The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of) pue aus ettending physician for use as the burie Colfable Box 68760. Physician/Medicai Due to (or as a consequence of): 88 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. the 1 Yee 2 No 3 Probably 4 Unknown signed by 0 þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed Deen certificate hes 2 0 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Placa of Daath (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 R/Outpatient 3 DOA 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After ! 5 Pending investigation Attending s effer deau... af Director: Affe 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours e To the Funeral C completely filled edical 29a. Certifiai 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16840 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Salisbuld, 547 F BALDADO m. 0. RIJUISIAL 32. Registrar's Signatura 31. Date filed (Month 9 1999

State Registrar

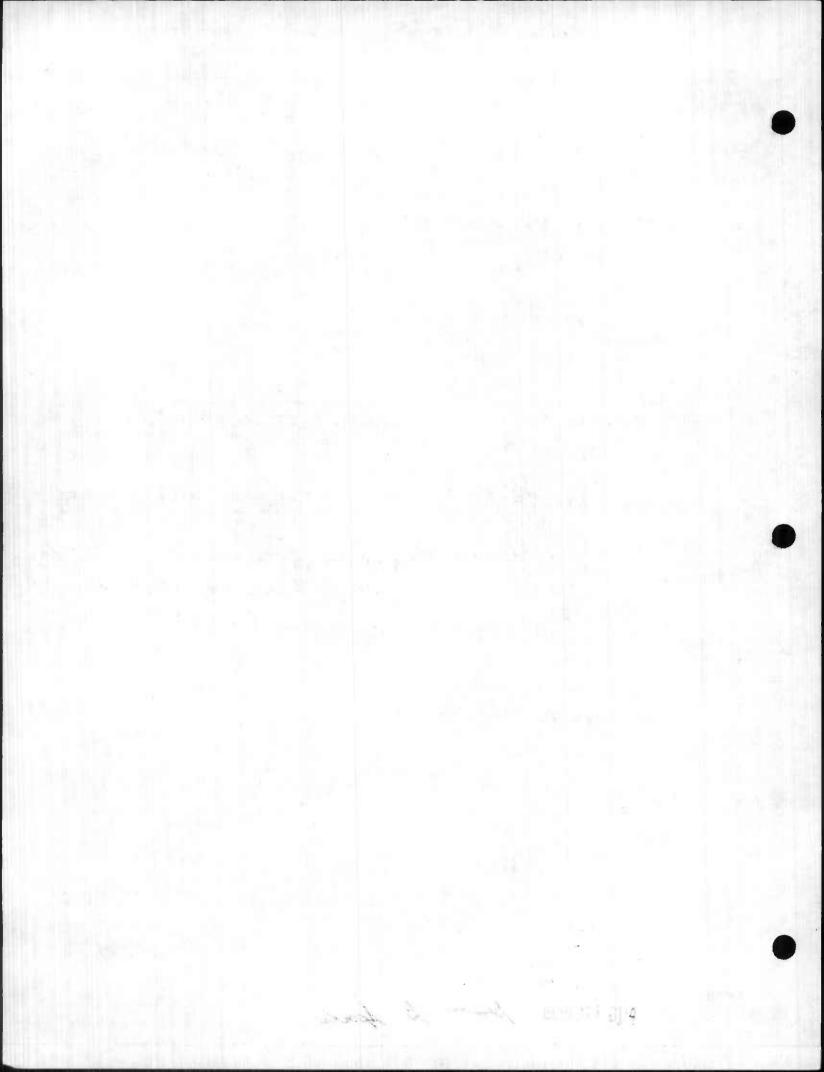
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State of Maryland / Department of Health and Mental Hygiene

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Division To the Hospital or Attending within 24 hours after Geath. To the Funeral Director: After completely filled in by the fun	edical C	29a. Certifiar (Check only one)		nyaician: To the besing and manner	of examinetion a							
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No

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Funeral Director filed within 72 hours after death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Baltimore, Maryland 21215-0020 MARGARET Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other then ' ury or other traumstic event, the Ma item 2. permit. Page Department of important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Physician /Medical Examiner Examiner sician and burial-transit The law requires that the death certificate be executed as the burial Box 68760. Physician/Medicai 980 P.O. Records, þ Completed certificate Division of Vital or Attending Physician: Be Medical Certification: To After this funeral within 24 hours after death. To the Funeral Director: Al filled in by fo the Hospital completely

1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Margaret Gable MUNDY AUGUST 6, 1999 6:15 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehabilitation Ctr. Berlin Worcester 8. Data of Birth (Month, Day, Year) Aug. 10, 1 If Undar 24 Hrs 5. Social Security Number If Under 1 Year 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country)
 VA Hours 10 M 2 F Months Days 577 03 4157 93 1905 Usual Rasidance of Decedent 10b. County 10a. Stete 10c. City. Town or Location 10d. Inside City Limits Worcester Ocean Pines 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Portside Court 21811 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ ØNo If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Rece - American Indian 11 Marital Status Bleck, Whita, etc. 1 Nevar Married 2 Married white 1 Yas 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) proprietor Clothing-retail 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) William Echols Foster Margaret Gable Clery 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jack W. Mundy (son) 540 Small Reward Rd., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Removel from Steta Cedar Hill Cemetery 8-11-99 Suitland, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service kicensee 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 20736 25a. Pert1. Enter the disease, or complications the persed the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final · Congestive disaasa or condition rasulting in death) Cononand M Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last Rtenios cleros Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OhstRuctin 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2K No 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2X No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 X Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, offica building, atc. (Specify) 4 Homicida 29a, Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical/Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only 29b. Signature and Min of 1 29c. License number 29d. Data signed (Month, Day, Year) D02026 30. Nama and addrass of person who complated causa of death (Itam 28a) (Type, Print) FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE OCEAN PINES MD 21811 410-641-4400 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature

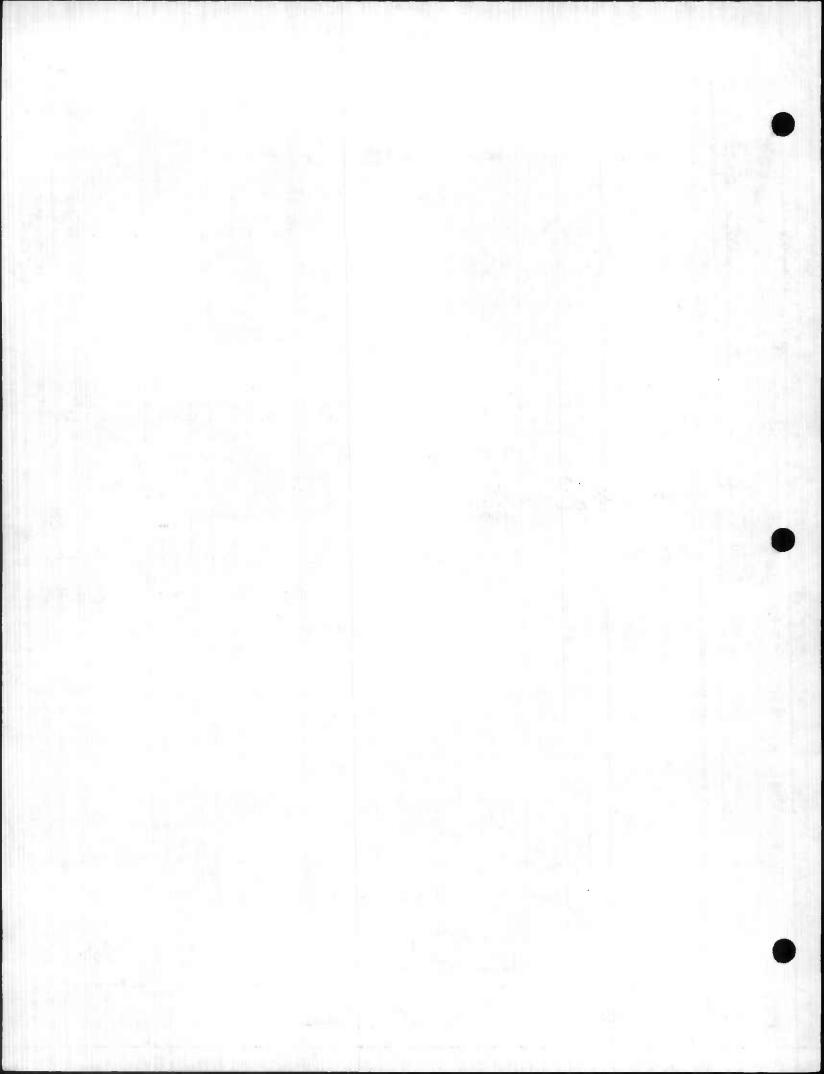
State Registrar

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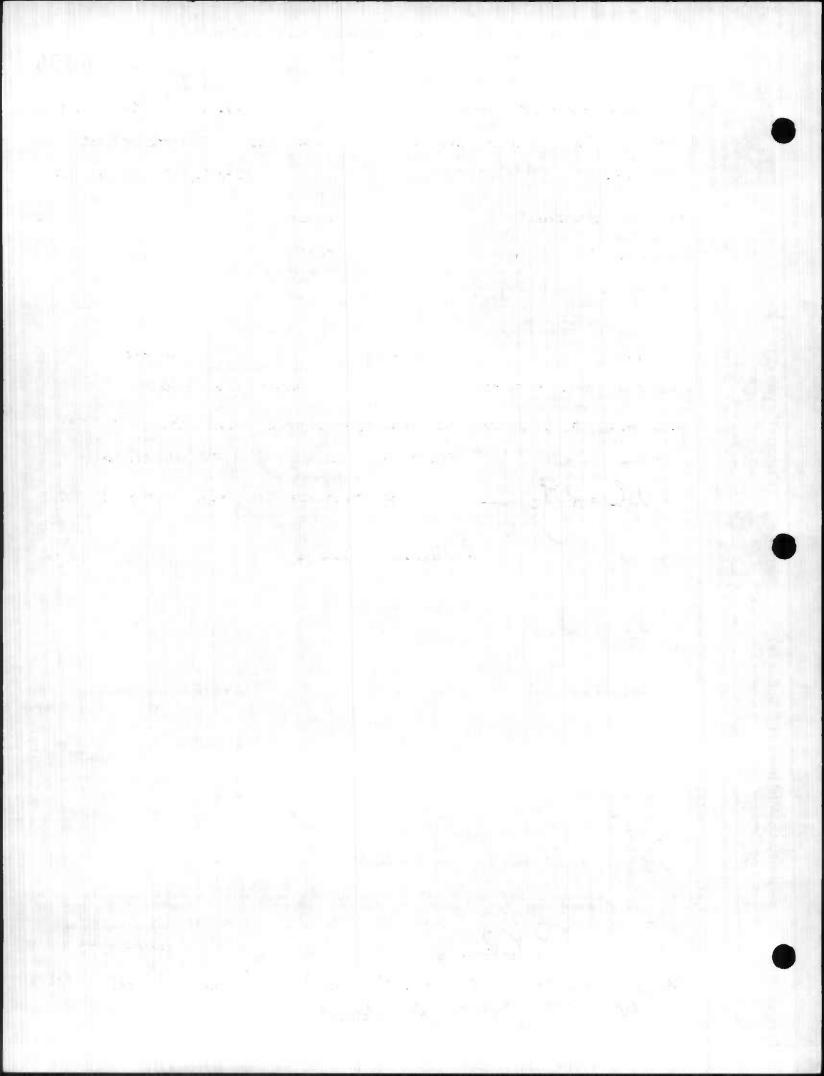


State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1999 9:41 a.m. DORTS **ELTZABETH** MOORE August /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis Elder Care Center, Spa Creek Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 257 F 579 26 0395 May 19, 1926 Director 73 Wash., D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Lothian Maryland Anne Arundel Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20711 5253 Ed Prout USA death v Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, While, etc. filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ₩ Widowed 4 Divorced Year or Dates: white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 10 homemaker own home other 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic avent page. 17. Father's Name (First, Middle, Last) Margie Elouise Knode William Brack Honeycutt 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20711 1110 Upper Lothian, MD Mrs. Carolyn A. Trott/ daughter Pindell Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Mem. Gardens 8-10-99 Waldorf, MD 22. Name and Address of Facility William & Rausch Funeral Home, P.A., Owings, MD 20736 complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only **Physiclan** Immediate Cause (Final disease or condition resulting in death) /Medical 13 years **Examiner** Due to (or as a consequence of) Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ot) certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence ot) SB ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 2 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 2 No 1 Tyes certificate Hospital or Attending Physician: funeral director Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No s efter death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours of Funeral 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner stated. edicai 29a. Certifier completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 129193 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 10 Cochrane Drive - Annapolis, MD 21401-7366 180 Admirol Stephen Killianmo 2. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



99-4715-033 ihm LAURIE ANN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death NEWMAN 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1999 **Physician** Laurie Anne Newman 02:35 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WILLIAM BEANS ROAD AND FEDERAL COURT PRINCE GEORGES Upper Marlboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 8 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 10 M 20 F Months Days 18 Director 218-17-9324 June 6, 1981 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Shady Side 1 Yes 2 No Director 25a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò mant be 1178 Grove Avenue 20764 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary US Census Bureau 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hants (If them 27 is marked oth jury or other traumalic even Be William A. Newman Marianne Maroudas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1178 Grove Avenue Shady Side, Maryland 20764 William A. Newman/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removel from State Department of important: If any injury or abos. Lakemont Meml. Gardens 8-19-99 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signature of Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) V8850 Examiner wood o Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai the Due to (or as a consequence of): USe as 1 ò Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 No Unknown signed t

Completed by page 2 : After this certifical a funeral director, p Be edical Certification: To

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certificate

Physician:

Attending

al or Attending after death. I Director: Aft

To the Hospital within 24 hours a To the Funeral D

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24b. Were autopsy lindings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 18 Yes 2□ No

25. Was case referred to medical examiner? 1 TYPes 2 □ No

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE

27. Manner of Death 1 DNatural 2 Accident 3 ☐ Suicide

4 | Homicide

28a. Date of Injury (Month, Day Year) 5 Pending 8.15.99 investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work? 0225 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred facility of GENERAL from 28f. Location (Street and Number or Rural Route Number, City or Town, State) Win Blans Rd. Fedral A. marboro

29a. Certifier (Check only one)

Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contilled

29c. License number 29d. Date signed (Month, Day, Year)

OCME

AUGUST 15, 1999

30. Name and admissrot

and cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

AUG 1 7 1999

32. Registrar's Signature

No see that the second

State of Maryland / Department of Health and Mental Hygiene 00

				Certificate of	Death		Reg. No.	9 26886	
ysician	1. Decedent's Neme (First, Middle, La. James Franci		. Sr.			2. Date of De Month August		3. Tima of Death 5:00 A.N	
Medical	4a Facility Name (If not institution, give street and number) 4b. City, Town, or I								
caminer	424 Riverview Dri								
neral	5. Sociel Security Number 6. S	Sex 7. Ag	e (În yrs. last bir			8. Date of Birt (Month, De	h	Arundel 9. Birthplace (State or Fore Country)	
ctor	577–18–0097	MXM 20 F 7	7	Yrs. Months Days	Hours Min.	Feb. 5.		Washington, I	
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n as Leastian					
M P								10d. Inside City Lim 1 ☐ Yes 2]()	
be notified Directo	Maryland Anne Aru	undel		Edgewater 10f. Zip Code			10g. Citizen of V	2 2	
Dir	424 Riverview Driv				1037				
Bra	11. Merital Status	12. Was Decedent I	Ever in U.S.			pecify Yes or No		USA e - American Indian,	
traminer must by Funeral	1 Never Merried XX Married 3 Widowed 4 Divorced	Armed Forces? WYes 2 □ No If Yes Give			Hispanic Origin? (S ean, Mexican, Puert Specify:	o Rican, etc.)		k, White, etc. White	
	15. Decedent's Ed	ducation		Decedent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry	
Be Completed	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)			(Give kind of work done tile. DO NOT use retire	during most of wor id)	rking			
Com	12th	Conogo (1 401 a	,	lectronics N	Mechanic		Federal	Government	
Be	17. Father's Name (First, Middle, Last)			18. Mother's Ner	ne (First, Middle,	e, Maiden Sumeme)			
2	На	Mar	y Regina	Gloriu	S				
	19a. Intormant's Name/Relationship (1) Jeannette L. O'Mea				urat Route Number, City or Town, State, Zip Code) Edgewater, Maryland 21037				
		ara/ wiie							
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removal from Stete		t Disposition (Name of ry, cremetory or other ple		Dete		City or Town, State	
	4 □ Donation 5 □ Other (Specify		Metro	politan Cre	1	8-12-99			
8500	21. Signature of Edineral Service Light	2		George P. 2973 Solor	Kalas Fu nons Isla	neral Ho nd Rd. H	ome Edgewate	r, MD 21037	
sician	23a. Part1. Enter the disease, or com shock, or heart teilure. List only	plications that caused one cause on each lin	the deeth. Do	not enter the mode of dyi	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Deeth	
al	Immediate Cause (Final disease or condition Prostatic carcinoma								
er	resulting in death)	a		consequence of):				1 1/2 yrs.	
i e		h							
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	Due to (or as a	consequence of):					
Aedical Examir	that initiated events resulting in death) Last	C	Due to (or as a	consequence of):					
cian/N		d							
Sicis	Part II. Other significant conditions of	ontributing to death bu	at not resulting in	n the underlying cause gi	ven in Part I.	23b. Dld	lobacco use cor	ntributa to the cause of dea	
leted by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Yee 2XXNo	3 Probably 4 Unkn	
Completed						24a. Was perlo	an autopsy med?	24b. Were autopsy tinding available prior to completion of cause	
4 <u>G</u>								of death?	
ပိ	or Wasses of the second					10	2121	1 Yes 2 No	
0	25. Was case referred to medical examiner?	Hospitel: 1 ☐ Inpatie			h a a	eth (Check only o		(C1-)	
Ď,			Itpatient 3LI DOA	4LI Nursing H	lome 5 A Resid				
H	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	Voor!	M 1 Yes 2 No It home, tarm, street, factory, office 28t. Location (Street and Number or Rural Rout					
ToB	27. Manner of Death	28a. Date of Injur (Month, Day	(Car)						
cation: T	27. Manner of Death	9 00 50 (1-)	ury - At home, ta			28t. Location (S City or Tox	Street end Numb vn, Stete)	er or Rural Route Number,	
al direct	27. Manner of Death Valvetural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 27. Manner of Death 5 Pending Investigation 6 Could not be determined	28e. Place of Injubuilding, etc. ysician: To the basis of the basis o	iry - At home, ta :. (Specify) of my knowledge examination an		me, date and place	City or Tou	vn, Stete) cause(s) and ma	nner as stated.	
cation: T	27. Manner of Death 12 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only 27 Medical Exam	28e. Place of Injubuilding, etc	iry - At home, ta :. (Specify) of my knowledge examination an	rm, street, factory, office	ime, date and place opinion, death occu	City or Tou	vn, Stete) cause(s) and ma	nner as stated.	
cation: T	27. Manner of Death Valvetural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigation 6 Could not be determined	28e. Place of Injubuilding, etc. ysician: To the basis of the basis o	iry - At home, ta :. (Specify) of my knowledge examination an	rm, street, factory, office o, death occurred at the ti d/or investigation, in my	ime, date and place opinion, death occu	City or Tou	vn, Stete) cause(s) and ma	nner as stated. and dua to the cause(s)	
pletely filled in by the funeral of edical Certification: T	27. Manner of Death Valvetural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigation 6 Could not be determined	28e. Place of Injubulding, etc. yelclan: To the best of and manner sta	ory - At home, ta : (Specify) If my knowledge examination and ted.	or, death occurred at the tid/or investigation, in my	ime, date and place opinion, death occu	City or Tou	vn, Stete) cause(s) and ma	nner as stated. and dua to the cause(s)	

State Registrar

AUG 1 2 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26887 Certificate of Death 3. Time of Death 2. Dete of Death ent's Name (First, Middle, Last) **Physician** EEN /Medical 4e Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Georg 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day OCT 2,] 9. Birthplace (State of Foreign **Funeral** 10 M XX F Deys Michigan Months Hours B71-50-0461 49 Director Usuai Residence of Decedent the Maryland worle 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 25s-f show traumatic event, the Modical Examinar must be notified as 1 Yes 2 No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7502 Harrison Lane 20748 U.S.A. Funerai deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Bieck, White, etc. pernit. Peges 1 end 2 should be filed within 72 hours efter to Department of Heelth end Mentel Hygiene. Important: if item 27 is merked other than "naturel", or iten any injury or other treumetic event, the Medical Examine Back. 1 Never Married 2 Married White 1 Yes 2N No Specify: Maryland 21215-0020 Specify: Àq 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) American Legion #248 12 Bartender 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Awanda Ione Doremire James Carl Doner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7502 Harrison Lane Temple Hills, Maryland 20748 Stephen J. Olcott (Husband) Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place)

July | 27 pt 999 | 20c. Location - City or Town, State 20a. Method of Disposition Buriai 2 Cremation 3 Removal from State Maryland State Veterans Cem. Chelentham Maryland 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 2073 Th 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** MORE THAN /Medical Immediate Cause (Final CARCINOMA disease or condition resulting in death) 1 MONTH Examiner MORE THAN Examiner DF LUNG ARCINOMA 3 MONTHS physician end s the bunial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 8 Physician/Medical Due to (or es a consequence of): **USB 85** signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No p 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy Completed peen N/A page 2 has 2 No 1 ☐ Yes 1 □ Yes 2 □ No certificate Attending Physician: funeral director, Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending 1 TYes 2 🗆 No death. investigation al or Attendi s efter death I Director: A 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours o Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one)

State Registrar

DEALE CHURCHTON ROAD 31. Dete filed (Month, Day, Year) 32. Registrags Signeture JUL 2 3 1999 >

ganchard hirano

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) GYAN CHAND

29b. Signeture end title of certifier

DEALE oaks

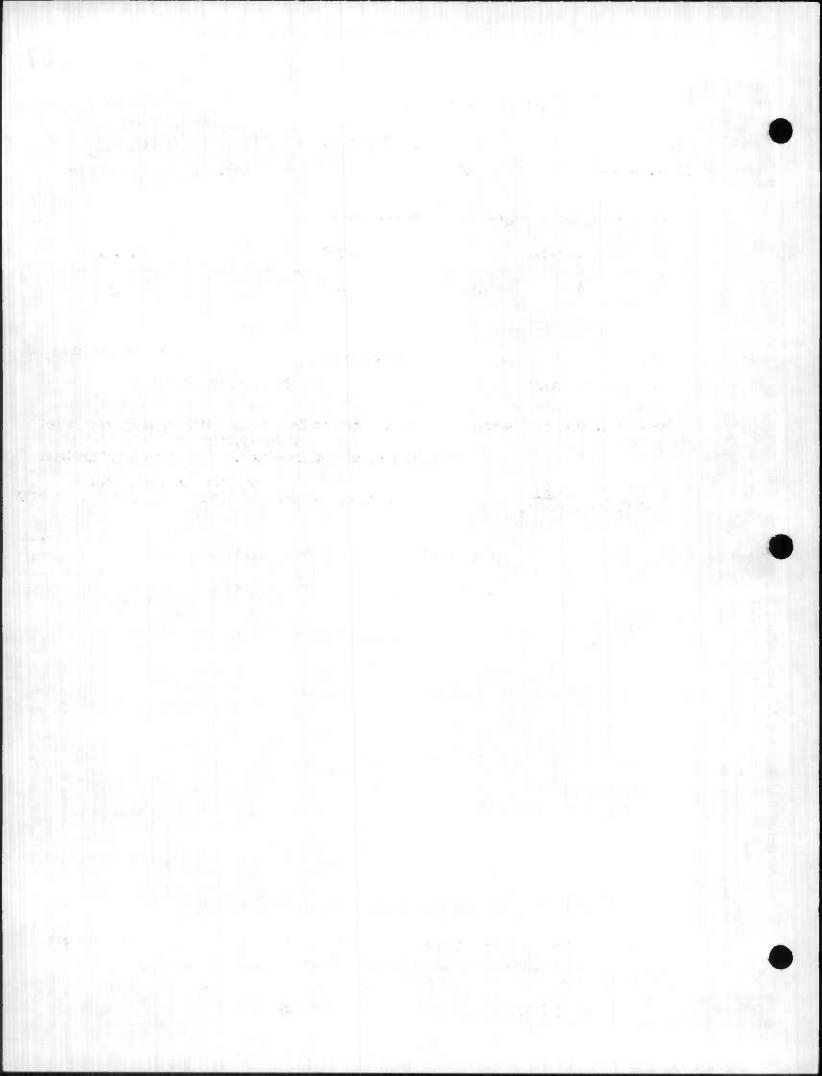
50653

29c. License number

29d. Date signed (Month, Day, Year)

7-22-

SURANA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Line # 5, 8/13/99 State of Maryland / Department of Health and Mental Hygiene Q Q 26888 Certificate of Death rjw, Cecil Co. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date U. Month **Physician** Pollock 5:38 pm Nancy J. /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** General Haspital Berlin MD Atlanti Workestor If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** Months 10 M 28 F 43 Days 8/16/55 Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director New Castle newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a United States Funeral 713 Cobble Creek Curve 19702 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yaar or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 3 Widowed Divorced "natural", White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than ' ury or other treumatic event, the Ma Elementery/Secondary (0-12) College (1-4or 5+) 8 Nursing Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) James McAllister Sally Ballard 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 713 Cobble Creek Curve, Newark, DE 19702 Christopher W. Abrams / Son Baltimore, 20b. Place of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Philadelphia Crematories, Inc. 8/13/99 | Philadelphia, PA</u> 21. Signatura of Funaral Sarvide Licensaa 22. Name and Address of Facility Beeson Memorial Services 2053 Pulaski Hwy., Newark, DE 19702

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one se Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Intraccrebral Hemory hage disease or condition resulting in death) Examiner Examiner Cerebral Edema Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Supratentoval Hernitta Physician/Medical Due to (or as a consequenca of): the the 98 Division of Vital Records, P.O. Box lack, Nancy signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings aveileble prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examine? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident or Attended 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide • Hospital 24 hours e • Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. edical 29a. Certifier To the To the To the 29b. Signature and title of cartifiar 29c. License number 29d. Data signed (Month, Dev. Year) Day 53612 0 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Hoffman MD 124 N. Mais st. Derlin, MD Mora 31. Dete filed (Month, Dey, Year)
AUG 13 1999 32. Registrar's signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q

26889 Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 13,1999 **Physician** 9:30 P.M. GARY WAYNE PHIPPS, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner GLADYS SPELLMAN SPECIALTY HOSPITAL PRINCE GEORGE CHEVERLY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (in yrs. last birthdey) 9. Birthplace (State or Foreign 1 M 2 □ F **Funeral** Months Days 41 JAN.8,1958 219-72-6214 VIRGINIA Director Usuel Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at NE Yes 2□No Directo MARYLAND PRINCE GEORGE CHEVERLY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20785 1 HOSPITAL DRIVE U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after death N Department of Haalth end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23t any injury or other traumatic event, the Medical Examiner meat publics. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates; 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 10 AUTO MECHANIC AUTO PARTS STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE KLINE PHIPPS RUTH FRANCES MATTHEW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ODEN PHIPPS-BROTHER WHITE PLAINS, MD. 20695 11064 DeMARR ROAD Baltimore, 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TRINITY MEM.GARDENS 8-19-99 WALDORF, MARYLAND 21. Signature of Euneral Service Licensee 22. Name end Address of Fecility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) hour 120 Examiner Due to (or as e consequence of): Examiner physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 99 Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown wholapethe A 24b. Were eutopsy findings available prior to 24e. Was an autopsy Completed peed completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital I Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 SNatural or Attending after death. 1 Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of 24 hours a
 Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the To the To the 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place #502 Seabnork, mo 20706 a.m ablanow 1404

DHMH 16 Rev 6/95

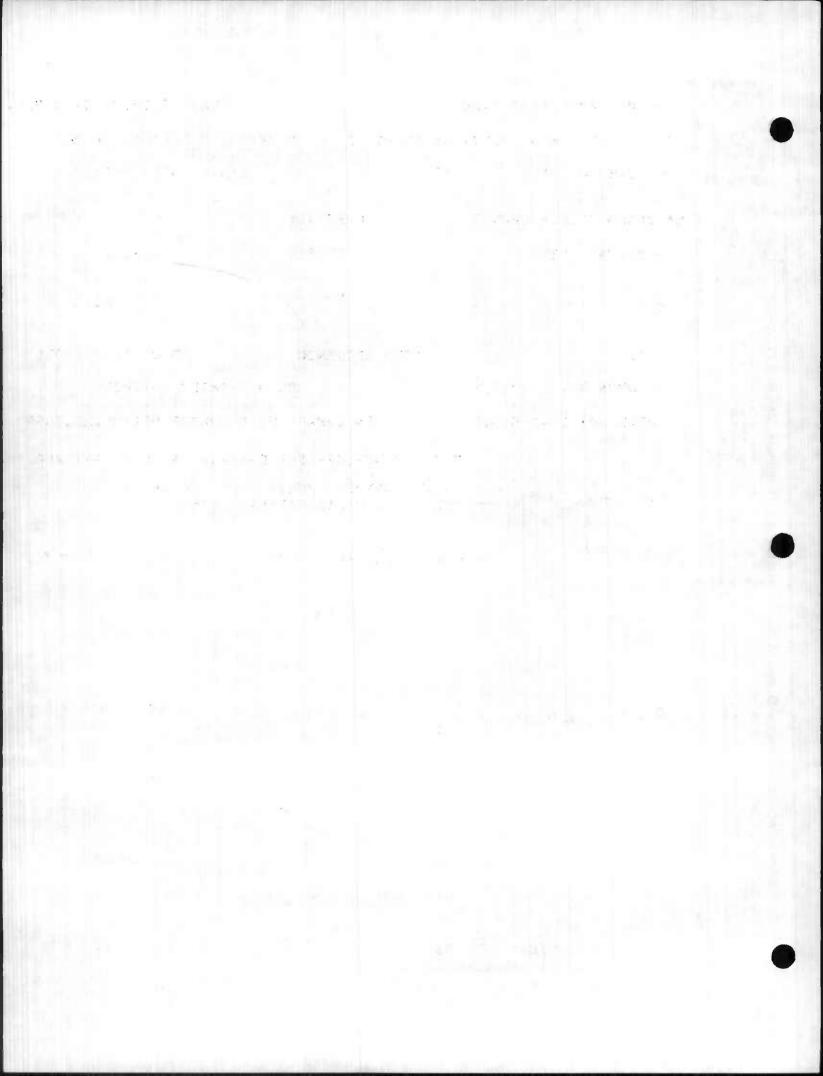
State Registrar 31. Date filed (Month, Dey, Year)

AUG

1999

32. Registrar's Signature

May provide



State of Maryland / Department of Health and Mental Hygiene 99 26890

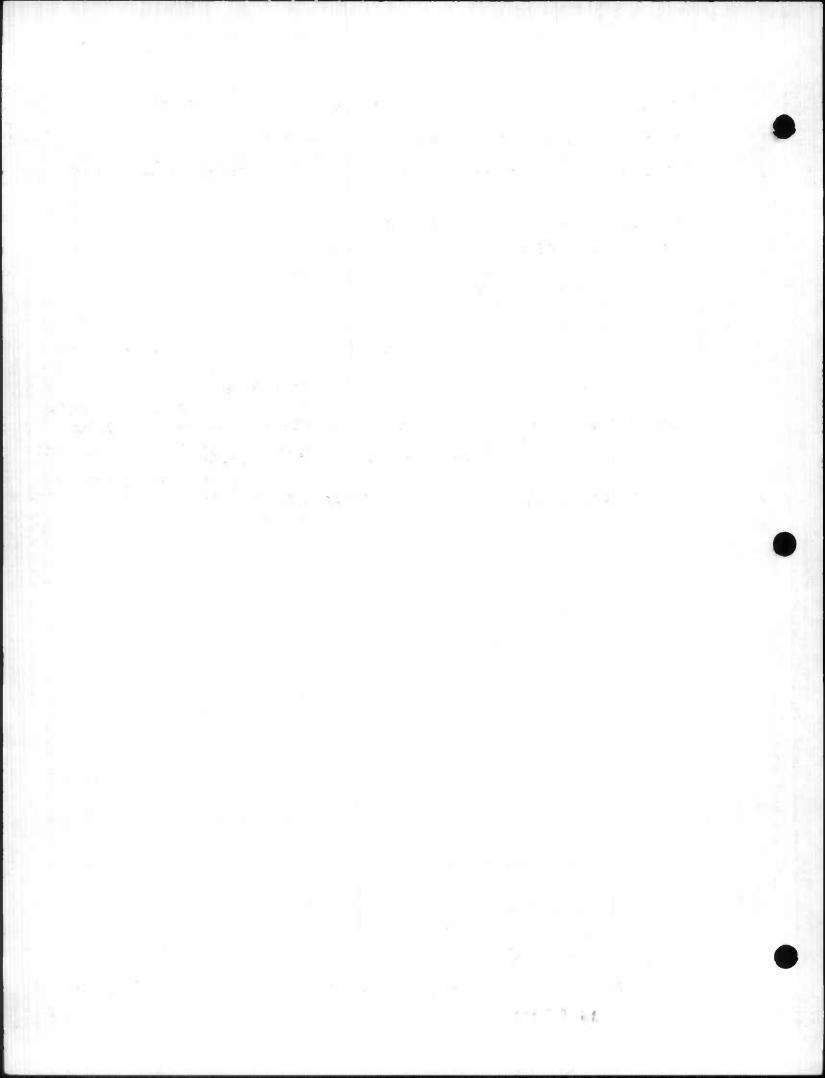
	Certificate of Death	Reg	. No.	20090
	Decedent's Nama (First, Middla, Last)	2. Data of Death		3. Tima of Death
Physician /Medical	JACK POWERS	Month 08/14/	Day Year	6:45 AM
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or		4c. County of De	ath
	SUNRISE CARE AND REHABILITATION FLATON		OPOTI	
Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year Trunder 24 Hrs	8. Data of Birth (Month, Dey, Y	CECIL 9. B	irthplace (State or Foreign Country)
Director	222-24-9826	10/1/19		VER, NJ
9 .	Usual Rasidence of Decedent			
with the Maryland to or 28s-f show the notified at	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
or 28a-f sh be notified.	DELAWARE NEW CASTLE WILMINGTON			1 Yas 2 No
Direction of the	10a. Street and Number 10f. Zip Code		. Citizen of What C	Country?
ath w	9 CATALPA AVENUE 19804		USA	
her death w r Herne 23e siner must.	11. Maritel Status 12. Was Decedant Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (S	pecify Yas or No- o Rican, etc.)	14. Race - Am Black, Wh	
	1 Nevar Married 2 Married 1 Yas 2 No Specify:		Specify: 1	מידינות
Maryland 21215-0020 62 should be tiled within 72 hours after the and Mental Hygens. 7 is marked other than 'natural', or is traumetic event, the Medical Examin To Be Completed by Fu	Taal of Dates.			WHITE
oct within 72 ho ygiera. ser than "naturin,", the Medical.	15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	tking 16	b. Kind of Busines	s/Industry
A PARTY OF THE PAR	Elementery/Secondary (0-12) Collega (1-4or 5+) CHEMIST	н	ERCULES,	TNC
Co President	12 CITE 131 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	na (First, Middle, Ma		INC.
Be ever			iden Sumama)	
To To	Grant Towns			
Man day	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			, Zip Coda)
CHN L	JOHN VAN SYCKEI 23 GORDON ROAD, WHART 20a. Mathod of Disposition 20b. Place of Disposition (Name of		885 c. Location - City o	r Town State
Dallimore, some 1 a separament of Hee mportant: If them my injury or other site.	1 Burial 2 Cramation 3 Removal from State cematery, cremetory or other place)	Data 20	c. Location - City o	or Town, State
tames (juny	4 Donation 5 Other (Specify) PHILADELPHIA CREMATORIES		ILADELPH	IA, PA
omilion in y in the part in y in the part in y in the part in the	21. Signeture of Funaral Sarvice Licenson 22. Name and Address of Facility BEESON MEMORIAL SI	ERVICES		
	2053 PULASKI HIGH		K. DE 19	702
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feilure. List only only cause on each line.	or respiratory arrest		Approximete Intervel Batween
Physician				Onset and Death
/ /Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death) a. Chremic Obstructive Long	DIFEGAR		years
	Dua to (or as a consequence of):			
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ob/ou, ifficate be executed to physician and as the bunal-transit		· · · · · · · · · · · · · · · · · · ·		
ourial MIE	Sequantielly list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disassa or Injury that initiated events Dua to (or as a consequence of):			
ficate be expensed to the purise the burise edical E	that initiated events rasulting in death) Last Dua to (or as a consequence of):			!
	d			
at the death certification of the death certification of the attending etached for use a Physician/M				
sed in	Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert i.	23b. Did tobe	cco use contribu	te to the cause of death?
d by the etache	Malnownstwent	1 □ Yes	2□ No 3☑	Probably 4 Unknown
The law requires that the de table has been signed by the a page 2 should be detached to mpleted by Physics				
ulcian: The law requires to cartificate has been signe rector, page 2 should be completed by		24a. Was an a		Were autopsy findings available prior to
has by ge 2 st				completion of cause of death?
The It		1□ Yes	2 1 No	1 ☐ Yes 2 ☐ No
Iclan: The certificate rector, pag		ath (Check only one)		
Physician: This certific ral director.	Hospital: _ Other	lome 5 Residence	ce 6 Other (Sp	pecify)
ding Physin. The this funeral di	27. Menner-of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Tima of 28c. Injury at fnjury Work?	28d. Describe how	injury occurred	
or Attending after death. Director: After in by the fune entification	2 Accident Invastigation M 1 Yes 2 No			
er de er de by il	3 ☐ Suicide 4 ☐ Homicida 6 ☐ Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (Stre City or Town,		Rural Route Number,
tal or Attending Pins attending Pins attending Pins attendenth. In Director: After the find in by the funeration: Certification:	Julian g, die jopeeny)			
To the Hospital or Attendible and the Hospital or Attendible to the Funeral Director: A completely filled in by the the Medical Certificati	29a. Cartifliar (Check only Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occur	, and dua to the cau	se(s) and mannar	as stated.
Pet Plets	one) and mannar stated.	irred at the time, date	and place, and di	ue to the causa(s)
To the composition of the compos	29b. Signetura end titla of certifier 29c. License number	290	Data signed (Mor	nth, Day, Year)
	Decleveno Des3322		0.16.40	7-
JIK	30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)			9-
0 (2)	Sheelmohan S. Sachder mp 118 North St.	ELKH	m ma	1. 21921
State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura			
Registrar	AUG 1 7 1999 Beneva B. Sparks			

ORIGINAL

DHMH 16 Rav 6/95

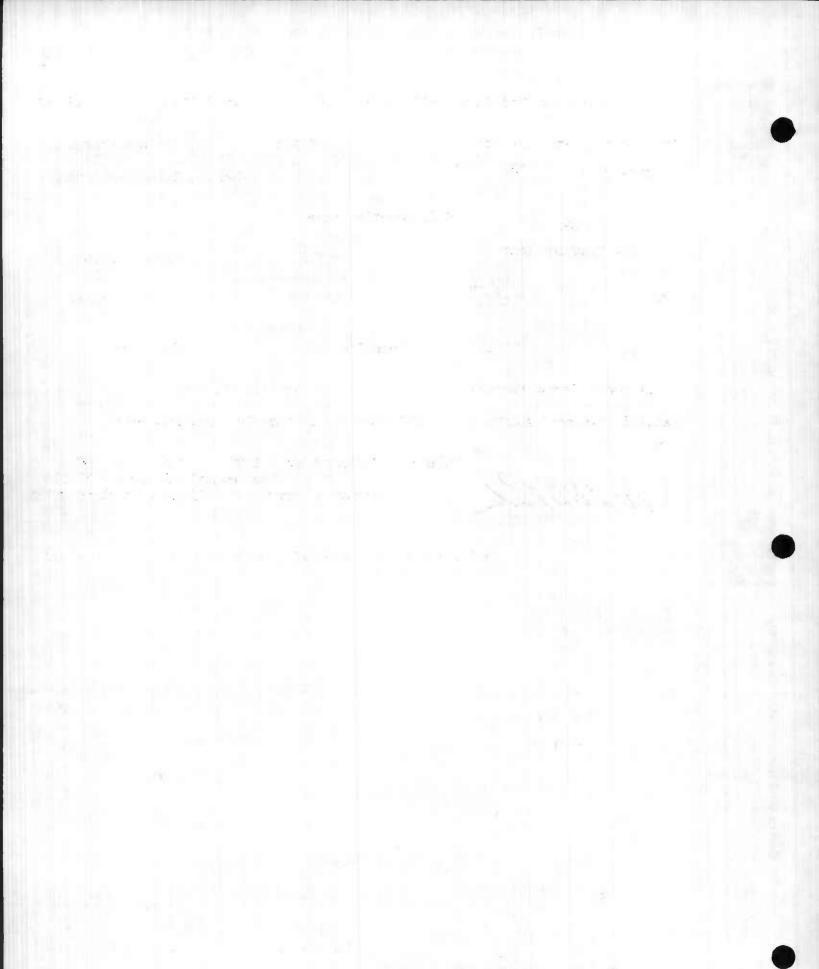
State of Maryland / Department of Health and Mental Hygiene 9 9 2689

			Ce	rtificate of	Death	Reg. N		16991	
Physic	ian	Decedant's Nama (First, Middle, Last)	71			ete of Death		3. Tima of Death	
/Medi		Jean		nillips			1999 ^{Yaar}	4 25 P	
Exami	ner	4a. Facility Nama (If not institution, give street and number) Asbury- Solomons Healt			4b. City, Town, or Location Solomons	(c. County of Deeth Calvert		
Funeral Director		132 28 6338 1□M 2□XF 66	a (In yrs. last birthdey) Yrs.	Months Deys		ata of Birth fonth Day, Yea 1 3,	9. Birth New New 1	placa (Stata or Foraig	
and w		Usual Residence of Dacedant 10a. Stata 10b. County	10c. City, Town or Lo	ocation			T	10d. Insida City Limit	
Maryl	ě	Maryland CAlvert	Solomon					1 □ Yas 2 ♥□ N	
a or 28a	Funeral Director	10e. Street and Number 11632 Asbury Circle	BOTOMOT	10f. Zip Coda 20688		10g. 0 Un	Chizen of What Cou	ntry? ates	
within 72 hours effer death with the Maryland ene. than "natural", or ferma 23a or 28a-f ehow to Medical Evantines must be notined at	by	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedant Armed Forcas? 1 Yes 200 If Yas, Giva Yeer or Detas:	No	Wes Decedent of I If Yas, specify Cub 1☐ Yas 2☐Xo	Hispanic Origin? (Specify Yoan, Mexican, Puarto Rican	'es or No- , atc.)	14. Race - American Indi Black, White, etc. SpecifyWhite		
b. natur Medical	Completed	15. Decadant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Giva		upation a during most of working red)		16b. Kind of Business/Industry		
Total Control of the last	Соп	*	" nu	ırse			Health	Care	
0 0 0	Be	17. Father's Name (First, Middle, Last) Fred Gray			18. Mothar's Name (Firs		ın <i>Sum</i> ama)		
d 2 should be 1 th and Mental I 7 is marked of traumetic eve	10	19a. Informant's Name/Raiationship (Type, Print)	10h Molli	ing Address (Ctron			or Town State 7	o Codel	
d 2 strain are train		Kent Phillips- son	1110	O Δehur	and Number or Rural Rou y Circle/	u non 1 + h	Care C	D°20688	
permit. Peges 1 and Department of Heelth Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)	20b. Piaca of Dispo cematary, cree Metropol	osition (Neme of amatory or other pla	De		Landing Observer	own, Stete aVirgini	
permit. P Departme Importan any Injur		21. Signature of Funerel Service Licensee	22	2. Name end Addre	ess of Fecility Rau	sch Fu	neral F	Home PA	
		23a. Part1. Enter the disease, or complications that caused			nes Is. Rd.		REPUBLI		
Physician /Medical Examiner		shock, or heert failura. List only one causa on each lir Immediate Causa (Final disease or condition	na.		CARCINO		4	Approximata Interval Batween Onset and Death	
LAGIIIIICI	ě	rasattilg in doutil)	Dua to (or as a consec						
cate be executed physician and s the burief-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents	Dua to (or as a consec	quance of):					
= 00	Aedical	rasuning in daath) Last	Dua to (or as e consec	quance of):					
death cer e attendin ed for use	Physician/	d					i		
the eth	ysic	Part If. Other significant conditions contributing to death be	ut not resulting in the u	undarlying causa gi	van in Part f.		tobacco use contribute to the cause of dea		
signed by	by Ph					1 Yes	2 □ N 0 3 □ Pro	bebly 4 Unkno	
aw raqu is been 2 shoul	Completed t				2	4e. Wes en sut performed?	00	fare autopsy findings reliable prior to emplation of cause i death?	
The ate h	5					1 🗆 Yas	2 3 NO 1	□ Yas 2□ No	
Physician: The in this certificate he ral director, page	Be	25. Was casa rafarred to medical axaminar?		O	28. Piaca of Death (Che				
ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 1 Inopatie. 1 Inpatie 27. Manner of Death 1 Natural 5 Panding (Month, Day 2 Accident investigation		of 28c. fnju	4 Lill Horsing Homa	S Rasidance Describe how inj		fy)	
lal or Attending Possible to Select death. In Director: After the funeration by the funerations.	Certification:	2□ Suicide 6□ Could not be	ury - At home, farm, str c. (Specify)		28f. Le	ocation (Streat a lity or Town, Sta	and Number or Run (ta)	al Route Number,	
To the Hospital or within 24 hours effer To the Funeral Dir completely filled in	edical	29a. Cartifler (Check only one) 1 Certifying Physician: To the best of and manner ste	axamination and/or in	th occurred at tha ti	ma, data and place, and di opinion, daath occurred at	ua to tha causa(tha tima, data a	s) and mannar es a nd piace, and dua t	steted. to the causa(s)	
To th To th comp	Me	29b. Signature end title of curtifier	1	29c. Licens		29d. D	ate signed (Month,	Day, Year)	
		M. H. They	of my		26358	J	11 / 2-	1,1995	
		30. Name and address of person who completed cause of de	M) -	00	FRFD	trict,	Mi	-20621	
Sta Registi	-	31. Date filled (Month, Day, Year) 32. Registre	arla Signatura	6. 1.	na V				



State of Maryland / Department of Health and Mental Hygiene 9 9 26892

					Certificate of	of Death		Reg. No.	20036	•	
	1-11-	1. Decedent's Name (First, Middle					2. Date of D	eeth	3. Time of Do		
	Physician /Medical	Virgi	nia Sevilla	Russell	Bradley I	Paddy	Aug 1	,1999	3:20 A	M	
	Examiner	4e Facility Name (If not institution	give street and number,)		4b. City, Towr	n, or Location of Dea	th 4c. County	of Death		
40		Southern Marylan	d Hospital			Clinto	on	Princ	ce George's		
	Funeral	5. Social Security Number		ge (In yrs. last bin	Months D	ear If Under 24	Hrs. 8. Date of B Min. (Month, D	irth	Birthplace (State or F Country)	oreign	
	Director	578 18 1884 Usual Residence of Decedent	1□ M XX F	81	Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Washington		
dand	à W	10a. State 10b. County		10c. City, Town	or Location				10d. fnside City	Limits	
Ma	cto roto	MD P.G		Clinto	on				1 ☐ Yes 2	No	
vit th	or 28s-f s be notified Director	10e. Street and Number 9106 Pinev:	ew Lane		10f. Zip Co		10g. Citizen of What Country?				
the	e 23	44.44-2-10	12. Was Decedent	Ever in II C		20735	n2 (Specify Ves or N	United	States e - American Indian,		
11215-0020 within 72 hours after death with the Mandand	if Heelth and Martiel Hygiana. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	Armed Forces	7	If Yes, specify		n? (Specify Yes or N Puerto Rican, etc.)	Specify Specify	ck, White, etc.		
21215-0020	ted for	15. Decedent	s Education	16e.	Decedent's Usual O	ccupation	of working	16b. Kind of B	usiness/industry		
215	ygiana. nor than "naturn t, the Medical Completed	(Specify only highes Elementary/Secondery (0-12)	College (1-4or	5+)	(Give kind of work di	atired)	working	O II.	Home		
CA A	Mentel Hygiana. Rice of the transition of the t	12	5		Housewife			Own Ho			
and 2	double even	17. Father's Name (First, Middle,					s Name (First, Middle		ne)		
S die	should in marke			1				la M. Foster Rural Route Number, City or Town, Stete, Zip Code)			
Z 2	27 is m r traum	19a. Informant's Name/Reletionsl Patricia Gibson]	. Mailing Address <i>(St</i> 113 Parkwa						
a	item 27 other tr	20a. Mathod of Disposition		20b. Place of	Disposition (Name o		Date	-	City or Town, State		
mo	mt: #	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ood Cemete		5.1999	Washing	gton, DC		
Saltimore,	Department of Heelth important: if item 27 eny injury or other tr	21. Signature of Funeral Seprice	icepseo						Inc 6633 Old	1	
m 8	SESS	1/1/10	Stal		Alexandr	ria Ferry	Road, Cl	inton, M	Maryland 207	35	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each l	d the death. Do r	not enter the mode of	dying, such as ca	ardiac or respiratory	arrest,	Approximete Interval Betwe Onset and De	en	
	hysician	(Onset and De	atn	
	/Medical xaminer	fmmediate Cause (Final disease or condition resulting In death)	aA	eute	myo Car	mial	mtare	tion	4 days	١.	
	27070	The state of the s		Due to (or es a	consequence of):						
2	n end iel-transit Examiner		b						1		
, avec	n end iei-tra								1		
68760,	sicia e bur										
68	attending physician end I for usa as the bunel-transit Clan/Medical Examir	resulting In deeth) Last									
Box	r usa		d				-		1		
C dea	the att	Part II. Other significant condition	s contributing to death I	out not resulting Ir	the underlying caus	e given in Part f.	23b. Die	d tobacco uss co	ntributs to the cause of	death?	
P.O.	ed by the attend detached for us	TD	Dm				10	Yes 2□ No	3 □ Probably 4X U	nknowr	
S, S	signed be del		psi						1		
Records, P.O. Box 68760,	sate has been s pege 2 should	Se	ben					s an autopsy formed?	24b. Were autopsy find aveilable prior to completion of cau		
Sec.	has be 2 s								of death?		
_ F	s certificate he director, pege						10	Yes 2 No	1 Yes 2 N	0	
Vit.	certificate rector, peg	25. Was case referred to medical examiner?	Hospital:			26. Place of Other:	of Death (Check only	one)			
of Vital	五面	1 Yes 2 No	1 Dunpat			4 🗆 Nurs	sing Home 5 Res	sidence 6 Ott			
	After funer	1 Netural 5 ☐ Pendin		ay Year)	rime of 28c.	Injury et Work? 1 ☐ Yes 2 ☐ No		s now injury occur	100		
Sign	death stor: / the	2 Accident investig	ot be	iuny - At home, fe	rm, street, fectory, of			(Street and Numi	ber or Rural Route Numbe	er.	
Division or Attending	rs after death. I Director: After ted in by the funeral Certification:	4 Homicide determine	building, e	tc. (Specify)	im, subbi, lociory, or	noa		own, State)		. ,	
potte	ours fille	29a. Certifier 1NCertifying	Physician: To the best	of my knowledge	, deeth occurred et th	ne time, dete and	plece, and due to the	e cause(s) end m	anner es stated.		
- Ho	n 24 hou he Fune plataly fil edical	(Check only 2 Medical I	xaminsr: On the besis of and manner s	of examination and	d/or investigation, in	my opinion, death	occurred at the time	, date and plece,	and due to the cause(s)		
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification	29b. Signature and title of cartifier	And		29c. LI	cense number			ed (Month, Day, Year)		
			2nec		DU	F6478		8-2-	99		
	12	30. Neme and address of person	ho completed cause of	deeth (Item 23a)							
		Suresh A.	- 1 1			s Rd #	C 307.	climto	m. mo 2.7:	35	
	State	31. Date filed (Month, Day, Year)	32. Reģist	rar's Signature		nes		:			
	Registrar	AUG 03	1999	1	m. jago	na					



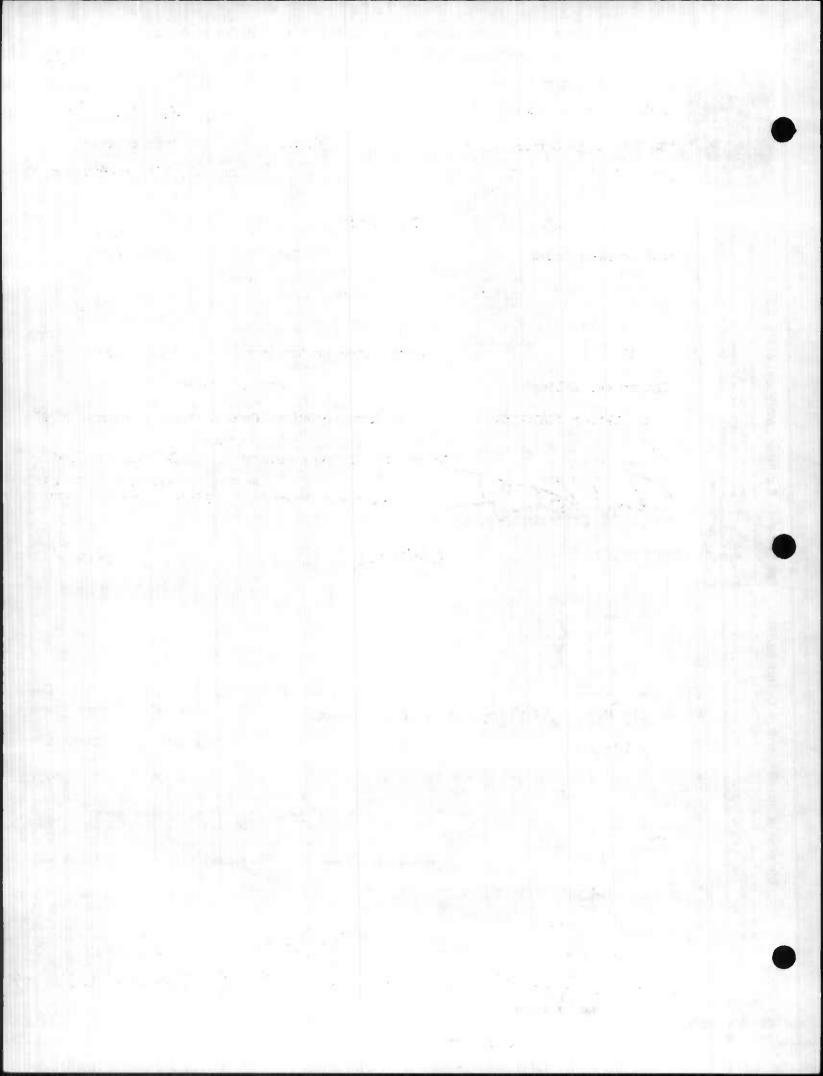
State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Lest) Month Dev **Physician** 9:15PM 26, 150 4c. County of Deeth Esther Lee Pennington July /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) Examiner Bradford Oaks Nursing Home Clinton Prince George 8. Date of Birth (Month, Dey, Year)

June 23, 1913

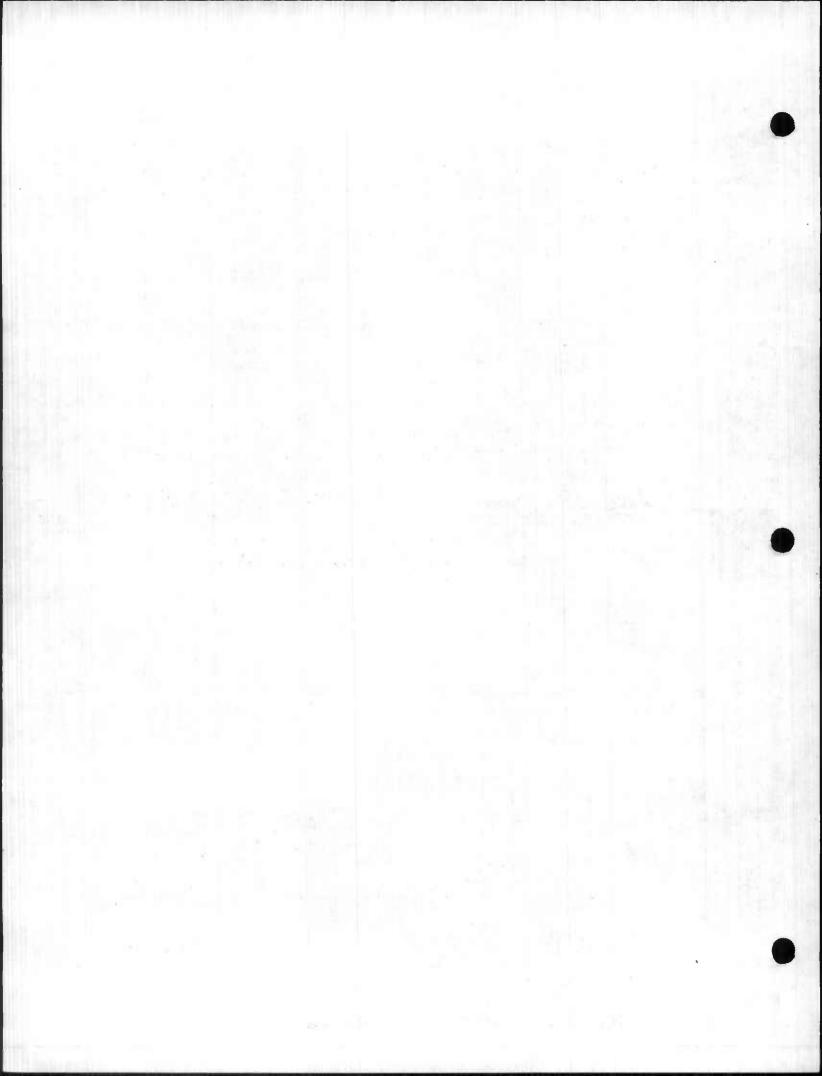
9. Birthplace (Stete or Foreign Caunty)
Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign **Funeral** 1□ M 2↓ F Months Deys Hours Min. Yrs. 578 12 5865 86 Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits lem 27 is marked other than "natural", or items 23s or 25s-4 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director P.G. Camp Springs MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 20748 United States 5209 Kenstan Drive 2 should be filed within 72 hours efter deeth nend Mental hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes XNo Specify: pA 3∰Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NOAA Elementery/Secondery (0-12) College (1-4or 5+) Travel Voucher Examiner Federal Government 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Martha Lederer Edward Lee Keller 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Ie in eny injury or other traun page. 5209 Kenstan Drive, Camp Springs, Maryland 20748 Ruth Haydon (DAUGHTER) 20b. Plece of Disposition (Name of cametery, cremetory or other place) July 30, 1999 20c. Location - City or Town, Stefe 20a. Method of Disposition 1 ∑Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland George Washington Cemetery 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 in 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, lock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Ceuse (Final disease or condition resulting in deeth) Examiner Examiner bunel-tran Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) tasf Bud Due to (or as e consequence of): Box 68760. physician certificate be Physician/Medical the Due to (or es e consequenca of) 88 usa Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. the s 1 Yes DE No à ente cansio varadose 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? nas a 20200 1 Yes ZONO 1 Yes 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospifal: Other: 4 La Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 25 No 1 ☐ Inpatienf 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Affer or Attending 5 Pending Investigation 24 hours efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - Af home, farm, streef, fectory, office building, etc. (Specify) 6 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 29e. Certifier Medical completely 2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stafed. (Check only within 2 To the ! 29b. Signature and title of capt 29d. Dete signed (Month, Dey, Year) n who completed sause of th_(Item 23e) (Type, Print) 0 LIVIN 32. Registra s Signature State 910000 Registrar

DHMH 16 Rav 6/95



ary Gertru	de Quillen	State of Maryla		ertificate of			Reg. No.	20074		
Physician	Decedent's Neme (First, Middle, Las					2. Dete of De Month	Dey	3. Time of Death		
/Medical	Mary Gertrude	QUILLEN				Augus	t 02, 19	999 10:15 A.M.		
Examiner	4e Facility Neme (If not institution, give	street end number)			4b. City, Town, or L	ocation of Deet	4c. County	of Death		
Negation 1	1950 Kingswood Dr			Wilness 1 Voss	Prince F	rederic	k Calve			
Funeral Director	207 20 2613	9x 7. Age (In yrs 77 77	Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Dete of Bir (Month, De NOV 9,	Dav. Year) Country)			
yland how	Usual Residence of Decedent 10a. Stete 10b. County	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location						10d. inside City Limits		
o Maria	Maryland Calvert				Prince F	rederic	<	1 ☐ Yes 2 No		
th with the Maryla 23s or 25s-f sho ust be notified at ral Director	10e. Street and Number 1950 Kingswood Dr	rive		10f. Zip Code	20678		10g. Citizen of What Country? USA			
ors after death vor. or flems 23e Examiner must by Funeral	11. Marital Status 1 Never Merried 2 Married 3 XWidowed 4 Divorced	12. Wes Decedent Ever In I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	J,S. 13	B. Wes Decedent of If If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - American Indian, ck, White, etc.		
72 hours return disal E		ucation	16a. Decedent's Usuel Occupation				16b. Kind of B	usiness/Industry		
Maryianu Zizi nd 2 should be filed within hill and Mental Hyglene. 27 is marked other than 'r r traumatic event, the Men To Be Comple	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired) homemaker				01	m homo		
	17. Father's Neme (First, Middle, Last)	1	HO	liellaker	18. Mother's Nam	a (First Middle		n home		
	Michael					10 (1 11 11), 11/10/10	Passmore			
	19e. Informent's Neme/Reletionship (7		-	iling Address (Street	Ednell	ral Route Numb				
	Michael J. Quille	n		me as # 10						
Fages 1 a reart of Hea writ: If Hem ury or othe	20a. Method of Disposition 1 □ Burlel 2 【Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removel from Stete Mo	cemetery, cr	ary, cremetory or other plece)			Oste 20c. Location - City or Town, State 3–99 Alexandria, VA			
Department Proportion Important any injurt	21. Signeture of Funeral Service Licens			22. Name and Addre	ess of Fecility			gs, MD 20736		
Physician /Medical Examiner	23a. Pent1. Enter the disease, or comp shock, or heart feilure. List only of Immediate Cause (Finel disease or condition resulting in deeth)	a. Arterioscle	rotic				rrest,	Approximate intervel Between Onset end Deeth		
P.C. BOX 08/00, at the death certificate be assected by the attending physician and etached for use as the bunal-transit Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lesf b. Due to (or as a consequence ot): c. Due to (or as a consequence of): d									
deat deat of for all sicia	Pert II. Other significant conditions co	entribute to the cause of death?								
ss that the igned by the be detache	Diabetes Mellitus					1 Yaa 2 No 3 Probably 4 Vunknown				
s been s s should	A A A							24b. Were eutopay findings available prior to completion of cause of deeth?		
VII IN IN IN IN IN IN IN IN IN IN IN IN I						10	Yes 2X No	1 Yas 2 No		
Physician: Thysician: Tal director, p.: To Be C.:	25. Wes case referred to medical examiner?	Hospitel:	3-00-	Ott	26. Place of Dea					
ng Ph her th meral	27. Menner of Death 1 Avatural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ 28e. Dete of Injury (Month, Dey Year)	28b. Time Injury	of 28c. Inju	4 Li Nursing H		dence 8 Oth how Injury occur	. ,		
To the Mospital or Attending Phymilips 24 hours after death. To the Funeral Street or After this completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At I building, etc. (Special	nome, ferm, s	street, factory, office			Street and Numb wn, Stata)	ber or Rural Route Number,		
he Hospiu in 24 houn he Funera pletely fille edical (aician: To the best of my kniner: On the basia of examinend manner stefed.								
To within	29b. Signe the and fittle of certifier	nelhell	/		c.M.E.		29d. Date signe August (od (Month, Day, Year)		
1*	30. Neme and address of person who c Margarita Korell				Street, B	altimor	e, Maryl	land 21201		
State Registrar	31. Date filed (Month, Dey, Year) AUG 0 4 19	32. Registrer's Sign		. Som	Kal					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dev Yea **Physician** THOMAS CLAUDE RHODES AUGUST 14, 1999 3:35PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner LAPLATA CIVISTA MEDICAL CENTER Hours Min. August 11,1933 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer **Funeral** 1XXM 2□ F Months Days 220-28-7321 66 Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 Yas 2 No Maryland Charles Directo Indian Head 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 72 hours efter deeth with 112 Charles Street 20640 United States Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1. Over 2 No 1951— If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black White etc. 1 Never Merried 2 Married 1 Yes ŽONo Specify: Specify: þ 3 Widowed 4 Divorced White Year or Dates: 1960 nd 2 should be filed within 72 hou alth and Mental Hygiene. 27 ia marked other than "natural or traumatic event, the Modical E. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Staff Sergeant National Guard 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Pegas 1 end 2 should be nent of Health and Mental Lomax Byron Rhodes, Sr. Helen Patricia Sprague 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Pnint) Health a 1707 Viewmont Drive, Los Angeles, California, 90069 Renee Rhodes/Daughter Baltimore, or other 20c. Location - City or Town, State 999 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) August 17, 1 Burlel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Maryland 20640 Pert1. Enter the phock, or heart in n, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel e Tschemic Heart diseese or condition resulting in deeth) unknown Examiner Due to (or as a consequence of): Examiner physician and s the burief-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) 60 attending for usa as signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2/24/99 Angioplasty à 24b. Were eutopsy findings availeble prior to completion of cause of death? 24e. Was an autopsy Completed I director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The saftar death.

Il Director: After this certificet of in by the funeral director, ps 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 dyes 2 No 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending 1 SNeturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steled.

2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signeture end title of certifier Tayum glina M. 8-14-99 D-50883 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) YAHIA M. TAGOURI, MD, ST. MARY'S HOSPITAL DEPT OF PATHOLOGY 25500 PT LOOKOUT RD

LEONARDTOWN. MD

Socks.

20650

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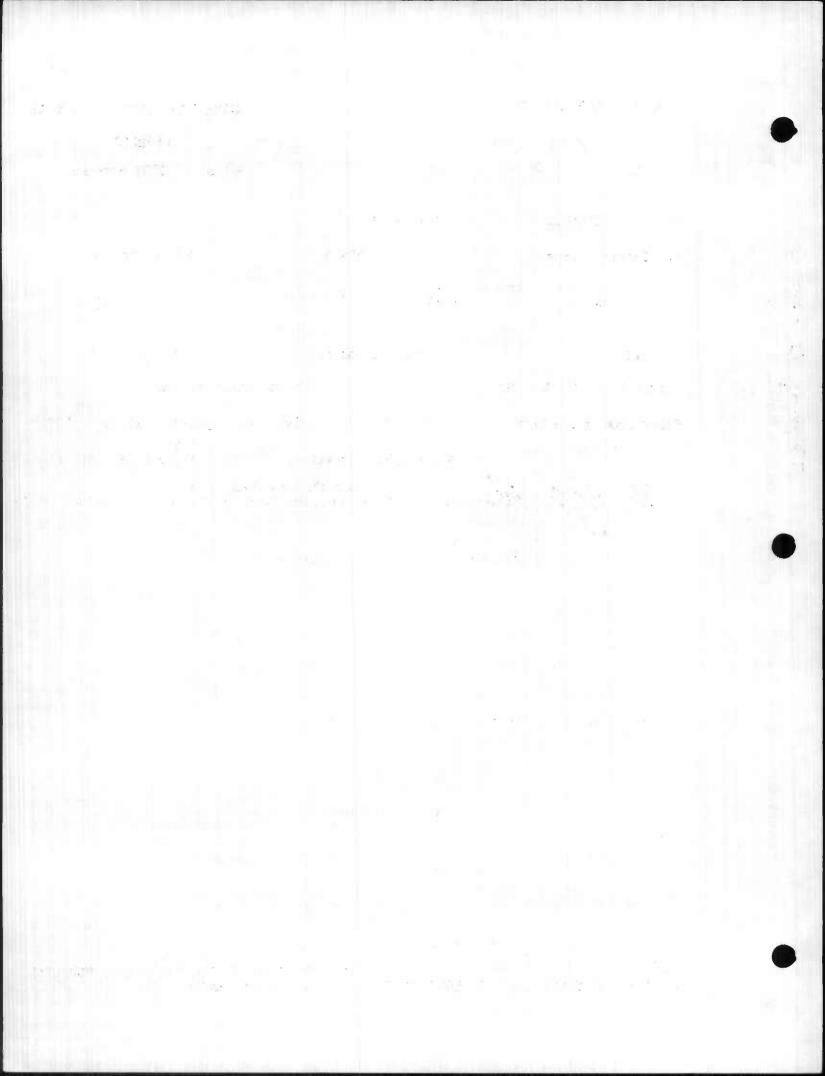
State

Registrar

31. Dete filed (Month, Dey, Year) AUG 17

32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene Q

26896 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 2140 Barry Wade Richardson 4b. City, Town, or Location of Deeth /Medical 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Dorchester General Hospital Cambridge Dorchester | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | June 19, 1961 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2□ F Maryland 38 Yrs. 221-46-1823 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 🕅 No Cecil Director Maryland Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21904 736 Principio Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pegas 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than 7 any injury or other traummatic event, in a strong injury or other traummatic event, in a Eleven Years College (1-4or 5+) Never Employed Never Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Luther John Richardson, Jr. Linda Keesev 19e. Informent's Neme/Reiellonship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Luther J. Richardson, Sr. (grandfather) 736 Principio Road, Port Deposit, Maryland 21904 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete St. Mark's Cemetery 8/17/99 Perryville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensii 22. Neme end Address of Fecility Lee A. Patterson & Son Funeral Home 23a. Pert1. Enter the disease, or complications that caused the beeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. gw Perryville, Maryland 21903-0188 Approximate interval Between Physician PNEUMONIA. ASPIRATION /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner UILERATIVE Examiner manuns sician and burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. signed by the attending physician be detached for use as the buria Physician/Medical Due to (or es e consequence of): RETARDATION. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ABNORMALITY FLECTROLYTE 3 Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to comptetion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital 25. Wes case referred to medical exemtner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury el Work? Certification: 5 Pending Investigation **CEN**aturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide *Excartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner stated. edical 29e. Certifier 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (ttem 23e) (Type, Print) street Camboridge MO Ahmed Dawaz 105 31. Dete filed (Month, Day, Year) AUG 1 6 1999 32. Registrer's Signeture Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥞 🖣 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Dey **Physician** Jerone ODINSON erbert ugust 99 825 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 503 d UNA HEAVNE 00/19 7. Age (In yrs. last birthdey) If Under 1 Yeer Months Deys 5. Social Security Number If Under 24 Hrs. 6 Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Hours 191-22-3807 Director 67 Aug. 10, 1931 Pennsylvania Usuel Residence of Decedent with the Meryland 10e. Stete 10c. City, Town or Location ?? Is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 17 Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 130 Hearn Rd. Apt. 503 21401 US deeth 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American indian. 11. Meritel Stetus Bleck, White, etc. 2 should be filled within 72 hours after end Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Never Merried 2 ☑ Married TV Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/industry 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) Temple University Eiementery/Secondary (0-12) Coilege (1-4or 5+) Retired 12th 0 Morque 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Robinson Ella Mayo 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 st Department of Heeith end Important: If Item 27 Is in any Injury or other traun Marty Johnson(Daughter) 1581 Ritchie Lane Annapolis, Md. 21401 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from State Metro Crematory 8-11-99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. 21. Signeture of Funerel Service Licensee 22. Name end Address of Feclity Wm. Reese & Sons Mortuary, P.A. 23e. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. 821 West St. Annapolis, Md. 21401 Physician Immediete Causa (Finel diseese or condition resulting in deeth) /Medical UNK. Examiner Due to (or es a consequance of): Examiner certificate be executed attending physician and for use as the buriel-transit Sequentielly list conditions, if any, leeding to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in daath) Lest Physician/Medical Due to (or es a consequence of) Pert ii. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the signed by the 3 Probably 4 Onknown 1 Yes 2 No P 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? Completed peeu hes 1 ☐ Yes 2 No certificate 1 TYes 2 No. 25. Wes cese referred to medicei exeminer?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital or Attending Phys 24 hours efter death. Funeral Director: After this funeral 27. Manper of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: 1 Naturei 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be datamined 3 ☐ Sulcide Piace of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the ceusa(s) end maintain as stated.

Medical Examiner: On the best of my knowledge, deeth occurred at tha time, data and place, and due to the ceuse(s) end menner steted. 29a. Certifian Medical pletely (Check only one) within 2 To the F 29c. License number

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State Registrar

31. Dete filed (Month, Dey, Year) AUG 1 1 1999

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30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print)

29b. Signeture end title of certifial

ones, wo 32. Registrer's Signeture

Deputy

95 Amorian

29d. Dete signed (Month, Day, Year)

3altimore, Maryland 21215-0020

Box 68760,

Records, P.O.

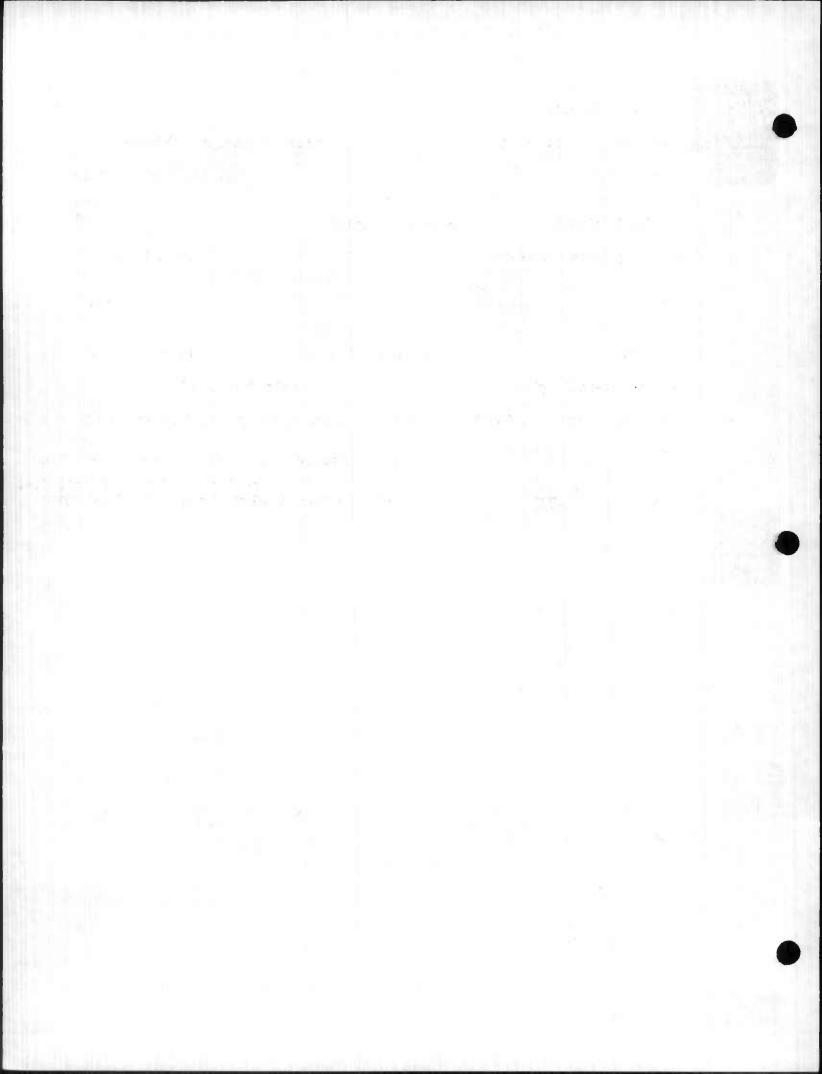
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State of Maryland / Department of Health and Mental Hygiene 99 26898

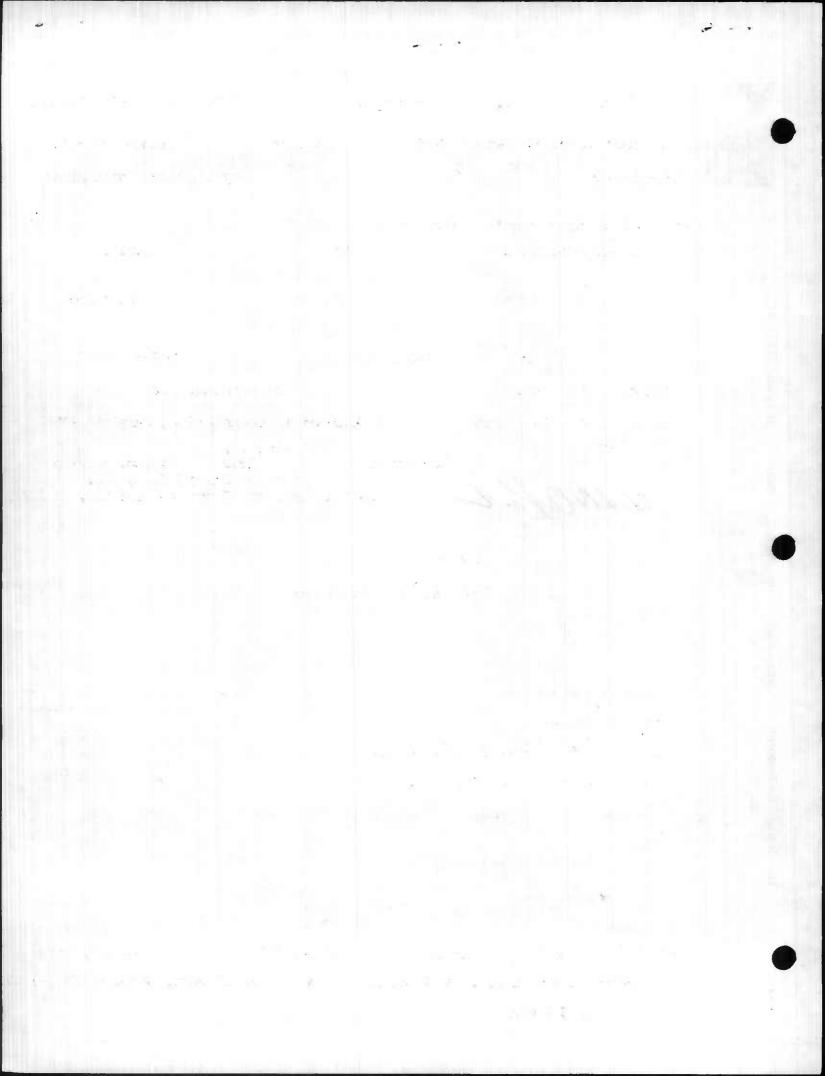
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Physician (Medical Examiner) 23a. Part I. Einer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inhand served conset interval served. The part is specified to the cause of each line. 25a. Part I. Einer the diseases, or complications and the part inhand served conset interval served. The part is specified and peach of the part is specified and peach of the part inhand served one of the part inhand served	חסוב	Departi Departi Importi any Inj		21. Signature of Funeral Service License	<u></u>				. 1						
The property of the property o	F	Physician		23a. Part1. Enter the disaase, or compli shock, or heart failure. List only on	cations that caused the cause on each line	ha death. Do	not enter the m	node of dyir	ng, such as cardia	c or respiratory er	rest,	war y ro	Approximete Interval Between		
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Second Part Second Part					1 ☐ Inpatient	2 ER/0	Outpatient 3	DOA Oth	er: 4 Nursing I	dome 5 ☐ Resid	lence 8 [☐Other (Speci	ify)		
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul Pomilla, M.D., Prince Frederick, Maryland 20678		ath. r: After ti	atlon:	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Injury			28d. Describe h	now injury o	occurred			
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul Pomilla, M.D., Prince Frederick, Maryland 20678		tal or Affers a start of the St	Certific	determined	28e. Place of Injury building, etc.	y - At home, f (Specify)	farm, straet, fact	ory, office							
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30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul Pomilla, M.D., Prince Frederick, Maryland 20678	-	of the of the office of the of			wing maintar state		2	29c. Licens	e number	Т	29d. Date :	signed (Month.	Dey, Year)		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 26899

Physician / Medical Examiner M	(Specify only higher Elementary/Secondary (0-12) 12 Father's Name (First, Middle) Mateo Pa. Informant's Name/Relation Imelda Mirand e. Method of Disposition 1 Burial 2 Geremation	P. In give street and number yland Hospi 6. Sex 1 M 200 F The George's cod Drive 12. Was Decede Armed Force 1 M Yes 2 M 11 Yes 2 M 12 Was Decede Armed Force 1 M Yes 2 M 12 Was Decede Armed Force 1 M Yes 2 M 13 Was Decede Armed Force 1 M Yes 2 M 14 Was Decede Armed Force 1 M Yes Completed) College (1-40 M + M A H) College (1-40 M + M A H) Pecson	tal Cen Age (In yrs. lass 69 10c. City, T Chel nt Ever in U,S. s? XNo s:	t birthday) If L Yrs. Mor Town or Location 13. Was E If Yes, 1 □ Y. 16a. Decedent's (Give kind of life. DO No.	Jnder 1 Yearnths Days of Zip Code 20623 Decedent of , specify Cut	Hispenic Origin? (S an, Mexican, Puert	8. Date of Birth (Month, Da) May 19	4c. County Prince Prince 1930 10g. Citizen of W U 14. Race Blace	9. Birthpli Count Phili	ace (State or For ry) ppines id. Inside City L 1 Yes 2 E ry? un Indian, tc.
Examiner of health and Merial hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s	Southern Mary Social Security Number 528-61-9803 Sual Residence of Decedent 10b. County 10b. State 10b. County 10b. Streef and Number 10503 Westwo 10b. Maritel Status 1 Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 2 Wall 10b. Never Married 10b. Never M	yland Hospi 6. Sex 1 M ZXF 7. e George's od Drive 12. Was Decede Armed Force 1 M Yes, Give Year or Date: College (1-40 4+ Last) Pecson	tal Cen Age (In yrs. less 69 10c. City, I Chel nt Ever in U,S. 3No s:	t birthday) If L Yrs. Mor Town or Location 13. Was E If Yes, 1 □ Y. 16a. Decedent's (Give kind of life. DO No.	nths Days n Zip Code 20623 Decedent of I, specify Cut es 2 X No	Clinton If Under 24 Hrs. Hours Min. Hispenic Origin? (S Dan, Mexican, Puert	8. Date of Birth (Month, Da) May 19	Prince 1930 10g. Citizen of W U	9. Birtholo Count Phili 10 /hat Count S.A.	ace (State or For ry) ppines id. Inside City L 1 Yes 2 E ry? un Indian, tc.
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinet must be mortified at 10s. To Be Completed by Funeral Director To Be Completed by Funeral Director 12. 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinet Ex	Social Security Number 528-61-9803 Sual Residence of Decedent Sa. State 10b. County Aryland Princ Streef end Number 10503 Westwo Maritel Status 1 Never Married 2 Maritel 15. Deceder (Specify only highe Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Mateo 3a. Informant's Name/Relation Imelda Mirand 1 Burial 2 Geremation	e George's od Drive 12. Was Decede Armed Force 1 Yes 2 If Yes, Green or Date: On this Education Set grade completed) College (1-40) 4+ Last) Pecson	Age (In yrs. last 69 10c. City, T Chel the Lyrin U.S. S?	t birthday) If L Yrs. Mor Town or Location 13. Was E If Yes, 1 □ Y. 16a. Decedent's (Give kind of life. DO No.	nths Days n Zip Code 20623 Decedent of I, specify Cut es 2 X No	Hispenic Origin? (S	May 19,	1930 1930 10g. Citizen of W U.	9. Birthpli Count Phili 10 /hat Counf S.A.	ace (State or For ry) ppines id. Inside City L 1 Yes 2 E ry? un Indian, tc.
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	Signature of Funeral Service	10 Jan	_			ess of Fecility L Alexandr	ee Funer ia Ferry			
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= 2 27	. Manner of Death	28a. Date of Ir (Month, I	njury 28	Bb. Time of	28c. inju			now injury occurr		
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Minn 24 hours after death. To the Funeral Director: After completely filled in by the fune fune. Medical Certification	4 Homicide	building,	etc. (Specify)				City or Tox			atod
edical		ng Phyelcian: To the bes Examiner: On the basis end manner	of examination							
29₺	b. Signature and title of certifie	er . ,			29c. Licen	se number		29d. Date signed	(Month, L	Jey, Year)
-	10	Hourl	A.D.	an Mara Dalam		30124		50)	12	4, 1999
30.	Neme and eddress of person	Howard M.D	. 7801	Old Br	anch A	Avenue #2	02 Clint	on, Mar	yland	20735-



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last 2. Date of Death **Physician** 4b. City, Town, or Location of Death 4c. County of Deeth 03 40 /Medical 4a. Facility Name (If not institution, giva street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year Months Days If Undar 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 214-12 5815 0 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at WILOMIZO t Nes 2□No Director ate view 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ,5 A ausec Funeral 14. Race - American Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) should be filed within 72 hours efter 1 ☐ Yas 2 M No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1□ Yes No ρ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Department of Health end Mental Hygiene. important: If Nem 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) Coilege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Majden Surnama, WilliEm Roberts Marions 19a. Informant's Name/Relationship (Type, Print) 6 1 nd 249 HS 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 8206 h Pige PJ M 20c. Location City or Town, Stata 20a, Method of Disposition Jostewille, M Burlal 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) P.O Box 6) MOO-IValue 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on come cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Acuts on ChroNic RESP FAICHRE Immadiata Cause (Final 48 112. disease or condition resulting in death) Examiner 49 AR Examiner ACUTU RENAL FAILURE physician end the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown PACEMALUM, þ 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of causa of death? 11/4 1 Yas 2/2 No 2□ No Division of Vital i or Attending Physician: after deeth. Director: After this certifica 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Unpatient 2□ER/Outpatient 3□ DOA 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha time, date and placa, and due to the cause(s) and manner es stated.

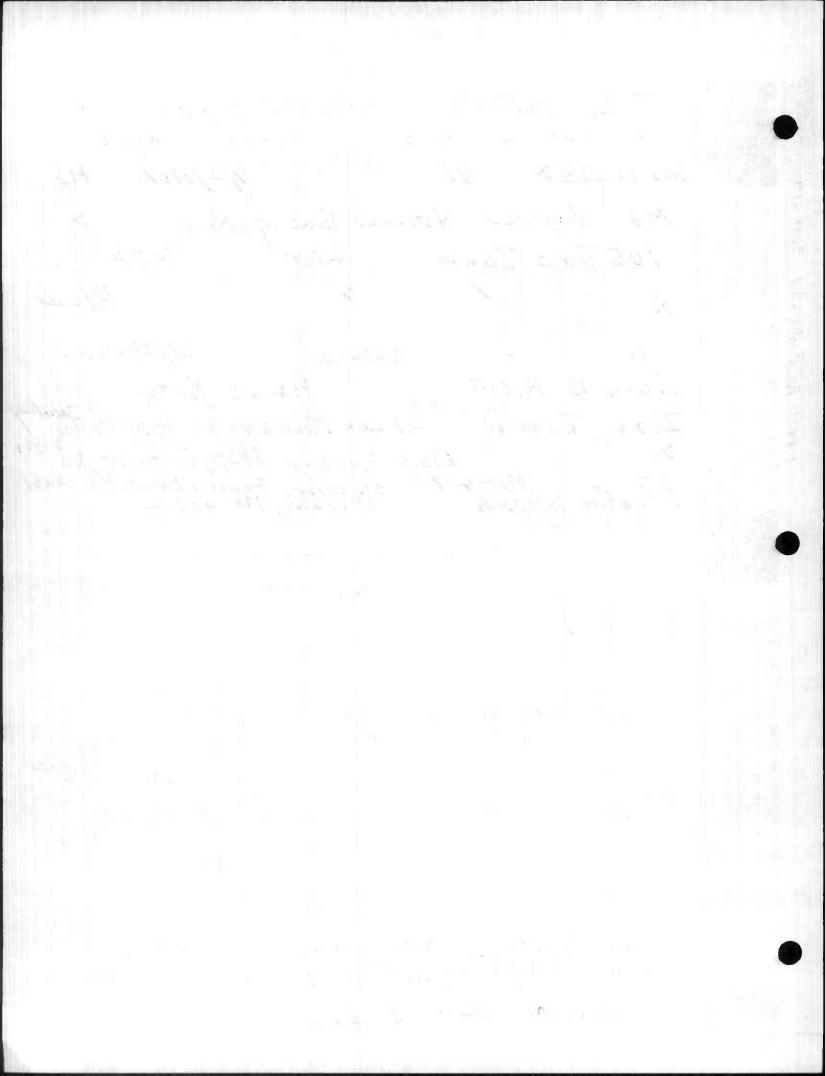
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifile 29c. License number 132014 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MD 106 MILPORD ST SUUT SOUR SALIBLUY

State Registrar MAMBY MOINDRA

AUG 1 1 1999

32. Registrar's Signeture

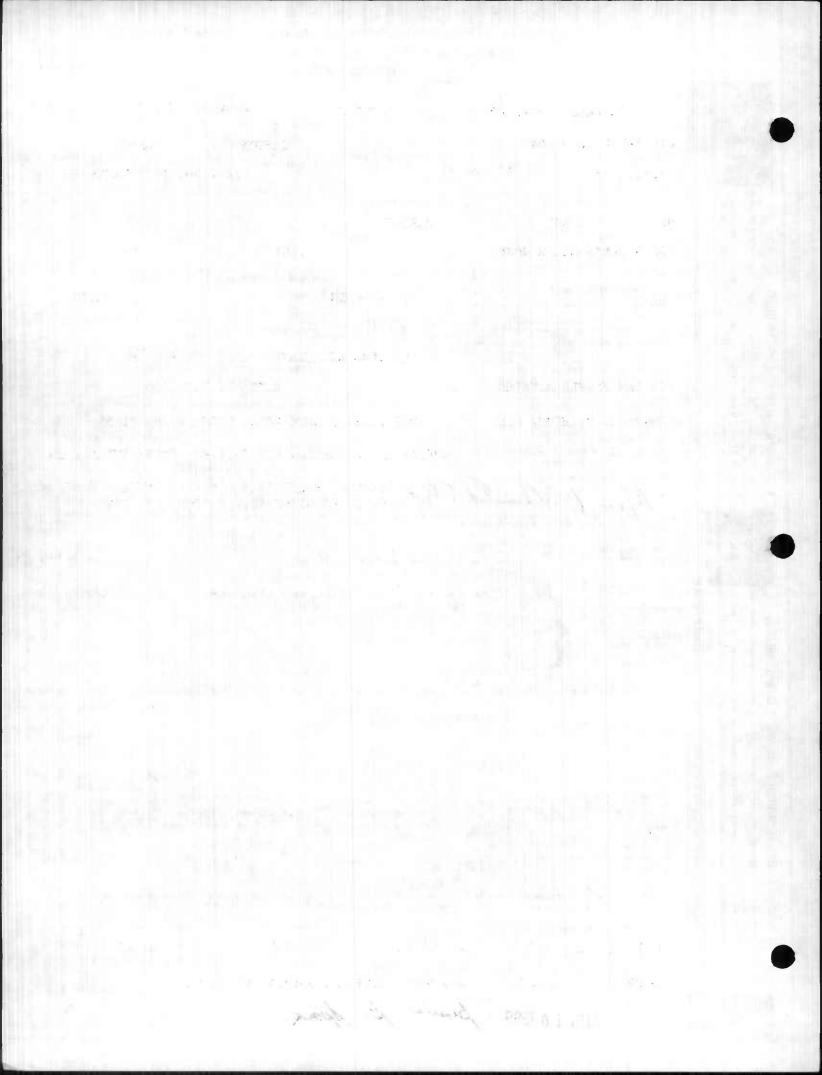
31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26901

4c. County TAL 9ar) 1909										
7, 1 4c. County TAL 1909	999 8:50pm of Death BOT 9 Birthplace (State or Fore Country) MARYLAND	1								
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1909	Birthplace (State or Fore Country) MARYLAND									
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Citizen of V	1√2 Yes 2□N									
10g. Citizen of What Country?										
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city Yes or No- 14. Race - American Indian,										
	ck, White, etc.									
Specify: WHITE										
h. Kind of Bu	usiness/industry									
5. 11.110 01 01										
HEALTI	н									
	I - Vincense									
	Stete, Zip Code)									
19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RICHARD H. STINSON/ SON 4985 FRAZIER NECK ROAD, PRESTON, MD 21655										
1 Yes 2 No 3 Probably 4 Unknow										
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	of death?									
2 0 No	1 ☐ Yes 2 ☐ No									
a 6 Oth	her (Specify)									
injury occur	rred									
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se(s) and m and pleca,	anner as stated. , and due to the cause(s)									
. Date signe	ed (Month, Dey, Year)									
Robert W. Trever, M.D. D10938 August 9, 1999 d address of person who completed cause of death (Item 23a) (Type, Print)										
	b. Kind of 8 HEALT iden Surnar ERSON ity or Town , MD c. Location STEVE M FUN , MD d. c. Location STEVE M FUN , MD d. c. Location STEVE M FUN , MD d. d. d. d. d. d. d. d. d. d. d. d. d.	b. Kind of Business/Industry HEALTH iden Surname) ERSON ity or Town, Stete, Zip Code) MD 21655 c. Location - City or Town, Stete STEVENSVILLE, MD M FUNERAL HOME, P. A. MD 21601 Approximate Interval Between Onset and Deeth Conset and Deeth Approximate Interval Between Onset and Deeth A								



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month TRA TROY SPARROW 13 1999 4b. City, Town, or Location of Death 8:20AM 4a Facility Nama (If not institution, give street and number) 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month Days Hours Min. (Month Day, Year) MAY 29, 1930 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplaca (Stata or Foreign 10XM 20 F Months VIRGINIA 230-30-5621 69 Usual Residence of Decedant 10a Stata 10c City Town or Location 10d. Insida City Limits 10b County 1 ☐ Yas 2 No MARYLAND CHARLES WALDORF 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 3575 FOREST VIEW DRIVE 20601 U.S.A. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 X No If Yas, Give Yaar or Datas: 14. Race - Amaricen Indian, 11. Marital Status Black White atc 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) OWNER/OPERATOR CARPENTER 18. Mothar's Nama (First, Middla, Melden Sumema) 17. Fathar's Nama (First, Middla, Last) CHARLES DAY SPARROW LUCY WIMBISH HYLER 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BILLIE JOYCE SPARROW/WIFE 3575 FOREST VIEW DR., WALDORF, MD 20601 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 8/17/1999 DANVILLE, VIRGINIA HIGHLAND BURIAL PARK re of Funeral Solvice Ligens 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Intarval Batween Onsat and Daath a. MYELODYSPLASTIC SYNDROME Dua to (or as a consequence of): DUA TO SEPTIC SHOYL immediata Causa (Final disaese or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 1 Yes 2 No 3 Probably Jugknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of causa of death? 1 Yas 2 No 26. Placa of Daath (Chack only ona) Hospital: Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 27. Manper of Daath 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

na 23a or 28a-f show

7 is marked other than "natural", or items traumatic event, the Medical Examiner ma

"natural",

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the second of the s

physician and s the burial-transit the USB as signed by the peed page 2 has cartificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completaly filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai à Completed Certification:

25. Was cesa rafarred to medicel axaminar? 1 Yas 2

> 1 Watural 2 Accidant 3 Sulcida

4 T Homicide 29a, Cartitian (Check only one)

5 Pending Invastigation

6 Could not be datamined

28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) Legitying Physician: To the bast of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated.

29b. Signatura and title of certifler

y Mar

29c. Licanse number D-28352

29d. Date signed (Month, Day, Year)

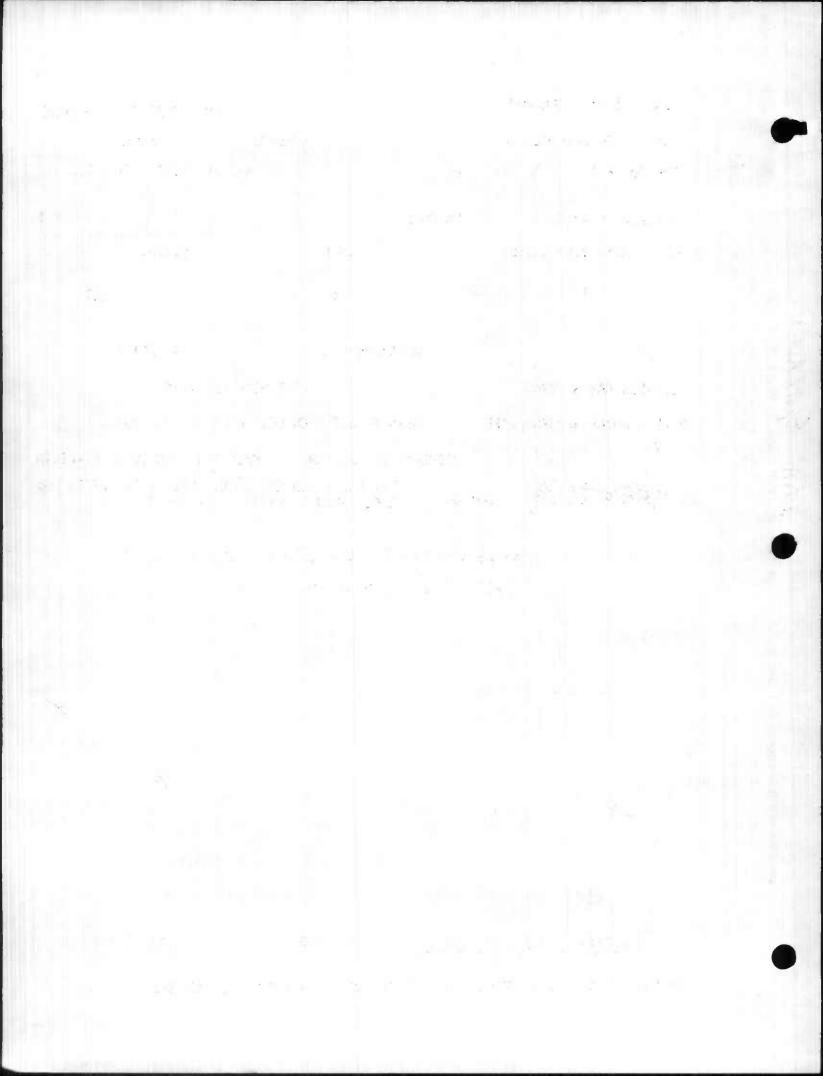
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR M.D. 3500 OLD WASHINGTON ROAD SUITE 102 WALDORF MARYLAND 20602 31. Date filed (Month, Day, Yaar)

State Registrar

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AUG 17 1999 32. Ragistrar's Signatura

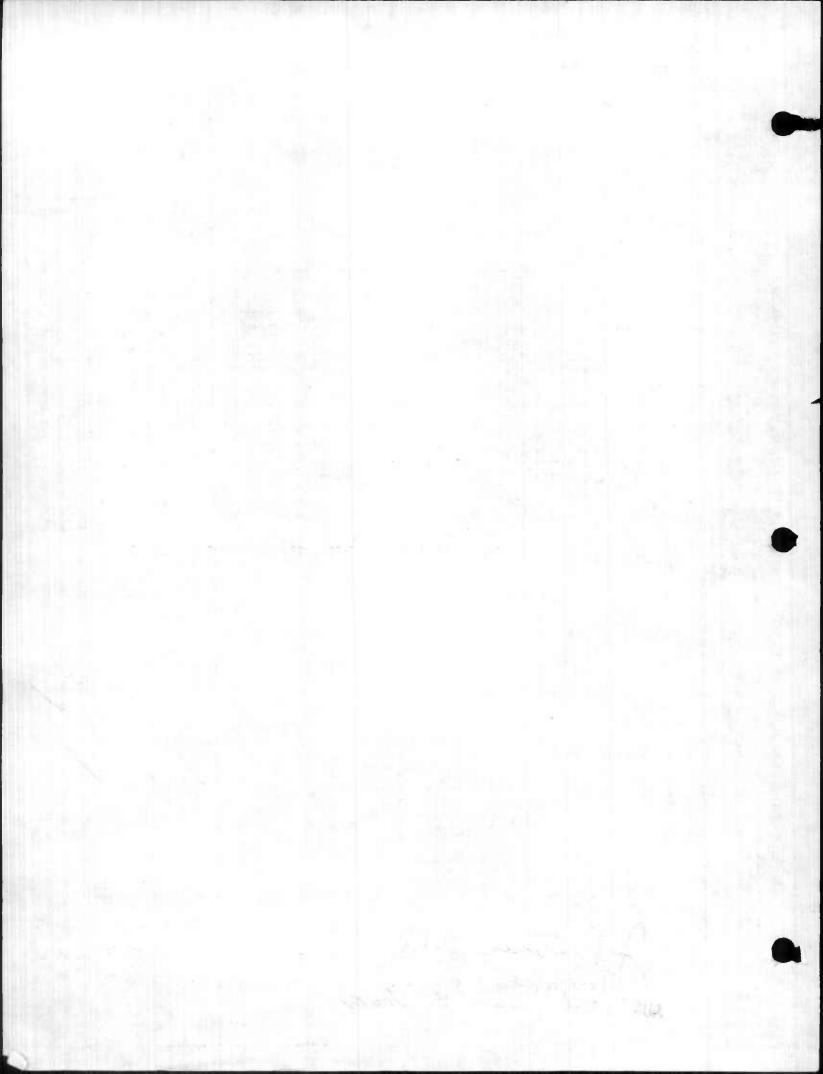


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CJ

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Physicia /Medica		STEVE EDWAR	D	SMITH							Augus		1999	01:30 PM.		
Examine		4a Facility Neme (If not Institution						4	b. City, To	wn, or Lo	cation of Deat	h 4c. Count	y of Death			
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Funeral		5. Social Security Number	6. Sex 1⊠ M		Age (In yrs.	lasf birthday, Yrs.	Months	Days	If Under a	Min.	n. (Month, Day, Year) Country)					
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	o Be	Vernon Smith									Justi					
M Do	F	19e. Informent's Neme/Reletion					er, City or Town	, State, Zip	Code)							
27 Is		Christine Lynn	Smith	/ Spc	11156	161 4	rhutue	· C+	root	FIL	ton, M	D 2102	1			
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State Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** Month RALPH L.SPOTTS 3000 8 /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) DOCTOR MILLER RD. ECIL Sex 1XM 2□ F If Under 1 Yeer 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys 162-28-0084 Usuel Residence of Decedent Yrs. JENNERSVILLE, PA Director Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If Itam 27 ie marked other than "natural", or Itama 23a or 28a-f ehow 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at NORTH EAS 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 1901 1.5-A MILLER Funeral Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1□ Yes 22No þ WAITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cgilege (1-4or 5+) COUNTY HEALTY DEPT. SANITARIAN UNKNOWN 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be WILBUR SPOTTS 19a. Informent's Neme/Raietlonship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RD WIFE BOCTOR MILLER LENA I- SPOTIS other t 20a. Method of Disposition
Suriel 2 Cremetion 3 Remove from State 20b. Piece of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, State Important: If it any injury or o permit. Pege Department RRKK FRIENDS 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Eureral Service Lio FUNERAL HOME s that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Physician /Medicai Immediate Ceusa (Finel diseese or condition resulting In daeth) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 036 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was casa refarred to medical examiner? 28. Placa of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcide 24 hours a Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end pieca, end due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end pieca, and due to the cause(s) and menner stated.

| Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end pieca, and due to the cause(s) and menner stated. 29e. Certifier edicai (Check only one) To the To the To the F

Registrar

31. Dete filed (Month, Dey, Year) AUG 1 7 1999

calledo

29b. Signeture and title of certifier

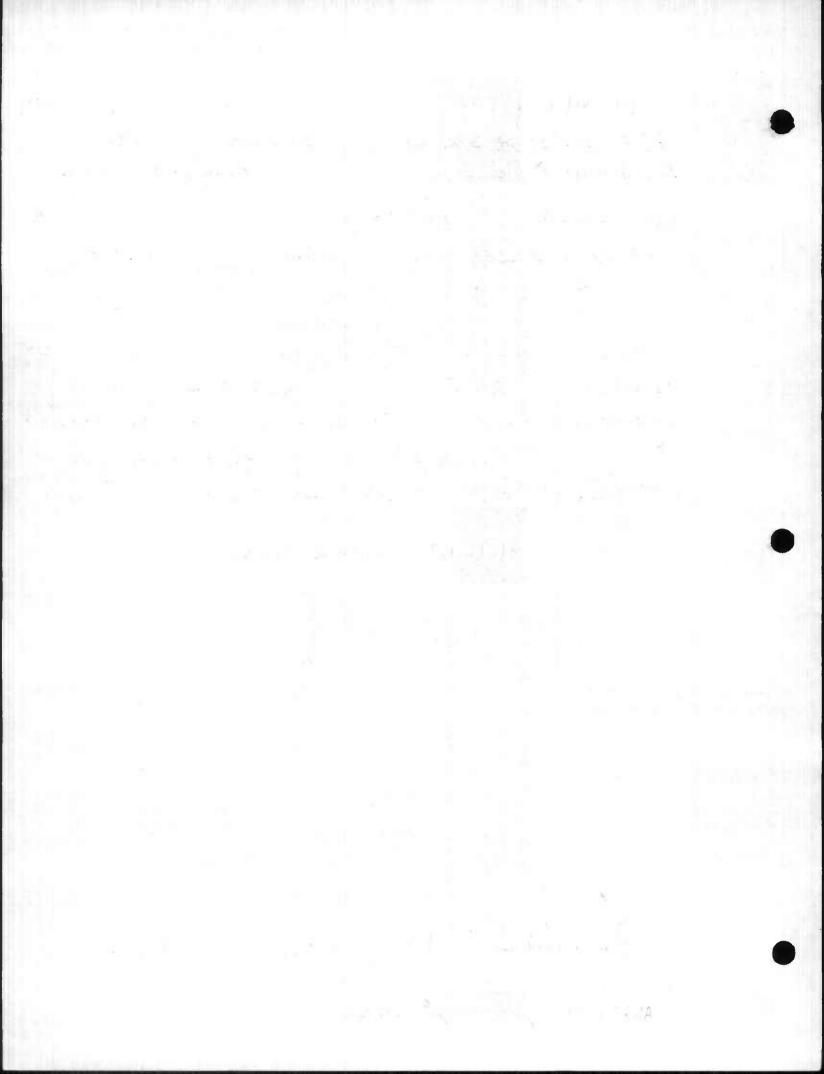
32. Registrar's Signature Ja.

30. Nama and addrass of person who completed causa of daath (Itam 23e) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year)

12



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 2. Date of Deeth 1. Decedant's Nama (First, Middle, Last) 3. Time of Death Smith **Physician** hristine 1999 6:00AM /Medical 4b, City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) **Examiner** Lothian Anne Arundel 1336 Marlboro Rd. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1□ M 25 F Yrs 87 Maryland **Director** 220-16-4694 May. 28, 1912 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examinet must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Lothian 1♥ Yes 2□No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1336 Marlboro Rd. 20711 Funeral US 14. Raca - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, etc. 1 Yas 2X No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Homemaker 5th 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Franklin Pauline Franklin 19a. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Agnes Johnson (Niece) 1328 Marlboro Rd. Lothian, Md. 20711 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date Burial 2 Cramation 3 Removel from Stete
4 Donetion 5 Other (Specify) 8-13-99 Moses Lothian Md. 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailufe. List only ona causa on each line. Md. 21401 Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel disaasa or condition resulting in death) multiple myeloma Examiner Examiner attending physician and for usa as the burial-transit Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in daath) Lest requires that the death certificate be axecu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? No No 3 Probably 4 Unknown 1 Yes dementa þ 24b. Were eutopsy findings evaileble prior to 24a. Was en eutopsy performed? Completed completion of cause of death? certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 Other (Specify) After this funeral 27. Menner of Deet 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No after death Director: the Funeral Director of the Fu 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, Stele) 3 Suicide 28e. Pieca of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. Medical 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b, Signatura and title of certitian 29c. Licensa number new (weing, MV) 30. Name and address of person who completed cause ot death (Item 23e) (Type, Print) Best gate Rd, Annapolis, MD 2140 eanine Werner 32/Registrar's Signature 31. Date filed (Month, Dey, Year) State AUG 1 1 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ngust Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City MARY/AND Baltimone Hofren Invensity If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X 216-42-2610 Jun. 21, 1945 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1406 Hayes Rd. 21401 US Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, Whita, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify:Black 3 ☐ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Homemaker 10th 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Harry Hayes Margie Maynard 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Laura Smith (Daughter) 1406 Hayes Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State Mt.Calvary Church Ceme. 8-12-99 Arnold, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequenca of):

Physician /Medical Examiner

The law requires that the death certificate be assecuted

this

or Attending r death.

Division of Vital Records, P.O. Box 68760.

Important: If Itam 27 any Injury or other tr

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

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Pages 1 and 2 should be filed within 72 hours after name of Health and Mental Hygiene.
Int: If Item 27 te marked other than "netural", or Ite

Baltimore, Maryland 21215-0020

Examiner physician and s the burial-trans Physician/Medical USB þ Completed Be Certification: To Director: / To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by

Pa	art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably Munknown								
_			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Ves 2 No 1 Yes 2 No								
25	. Was case referred to medical	26. Place of Death (Check only one)									
	exeminer?	Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nu	sing Home 5 Realdence 6 Other (Specify)								
27	Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred								
	3 Suicide 6 Could not I determined		281. Location (Street and Number or Rural Route Number, City or Town, State)								
29		nysician: To the best of my knowledge, death occurred at the time, dete and miner: On the basis of examination and/or investigation, in my opinion, deet and manner stated.									

29d. Date signed (Month, Day, Year)

August

State Registrar

edical

31. Date filed (Month, Day, Year) AUG 1 1 1999

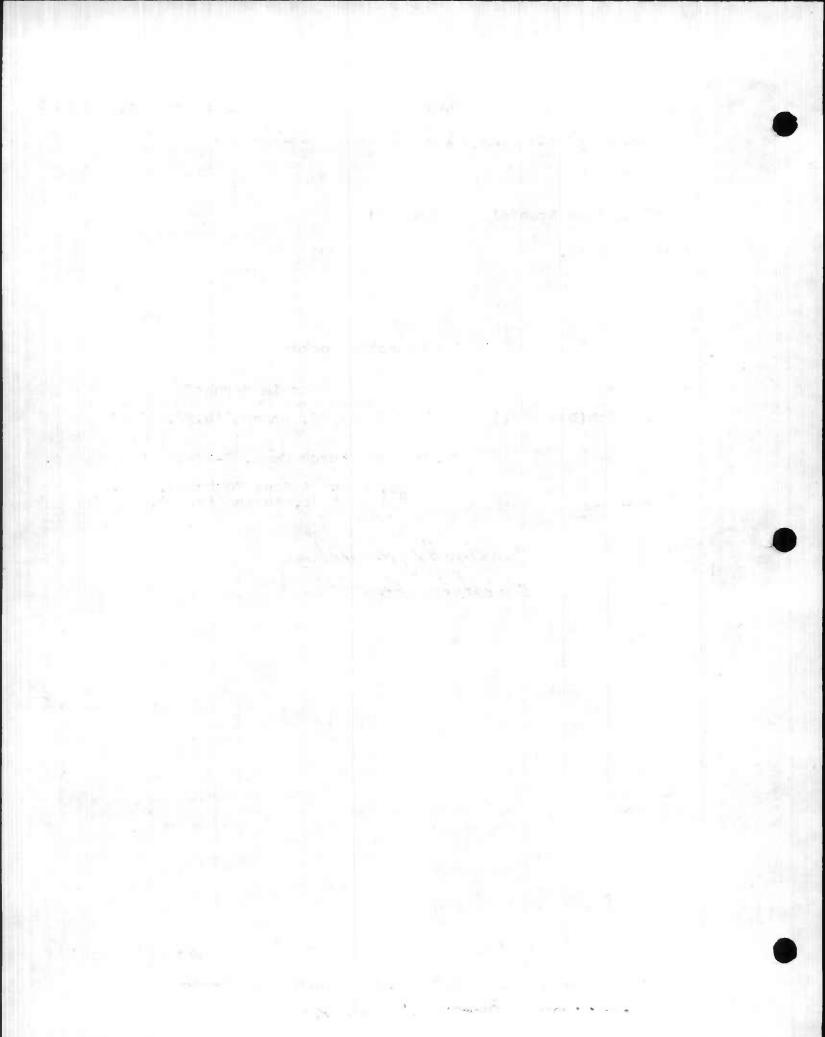
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signature and title of certifier

South Greene 32. Registrar'a Signature

St Baltimone Marylon

29c. License number # 3524



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) MonthLY 4999 10:30 P.M **Physician** Beverly 0'Bryant Scott /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner CHARLES LAPLATA CIVISTA MEDICAL CENTER If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Funeral Days Hours Months 1□M XXF Yrs. 577-26-6324 76 Feb. 28,1923 Washington DC Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in Medical Examinal must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10b. County 1 Yes 20 No Directo Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2235 Wakefield Circle 20602 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 11. Marital Stetus Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working lifa. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) 12th N/A Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) William Edgar Murphy Alice Newell Stone 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Patricia A. King (Daughter) 6571 Prairie Dog Ct. Waldorf, MD 20603 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20e. Mathod of Disposition 28th July Warial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 1999 4 ☐ Donation 5 ☐ Othar (Specify) Suitland, Maryland 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD Approximate 0735 23a. Part1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Daath **Physician** OF PANCREASE Immediate Cause (Final disease or condition resulting in death) CANCER /Medical Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, laading to immadiata causa. Enter Undarlying Cause (Disaase or Injury that initiated evants resulting in death) Lest Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of): signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ been signal 24b. Were eutopsy findings evallable prior to completion of cause of daath? 24a. Was en eutopsy performed? Completed certificata has b 1 ☐ Yes 2 🕽 📢 o 1 ☐ Yas 2 No or Attanding Physician: 25. Was casa referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Inpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2810 70 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Natural 2 Accident 5 Panding Investigation 1 Tyes 2 No hours aftar death actor: A 3 Suicida 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) the Funeral Dirac-4 Homicide Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end pleca, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end mennar stated. edical 29e, Certifia completaly (Check only one) within 2 To the I 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D-28352 30. Neme end eddress of person who complated causa of daath (Itam 23a) (Typa, Print) KRISHAN M MATHUR MD CAMBRIDGE PROF. CENTER SUITE # 102 WALDORF, MD 20602 31. Data filad (Month, Day, Year) 32. Registrar' Signature State JUL 2 Registra

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year **Physician** Mary Edith Smith 1999 Ju1v 30 9:25pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Civista Medical Center LaPlata Charles | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplece (State Country) | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Maryland | 19. Mary Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1DM XTF Months Yrs. Director Usual Residence of Decedent with the Merylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylen Department of Health and Menlet Hygiene. Important: If them 27 is marked other than "naturel; or theme 23a or 28a-f show any injury or other traumatic event, the Moural Evantine mass the northed as 1 ☐ Yes ※ No Maryland Charles Newburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20664 14740 South Cuckold Creek Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No if Yes, Give Year or Dales; Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Stelus 1 Never Married 2 Married Specify: Black 1 Yes X□ No Specify: by 3 Widowed Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) EDERAL Elementary/Secondery (0-12) College (1-4or 5+) ACCOUNTING CLERK GOYERDMENT 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) John Maurice Smallwood Eliza Marie Hill 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Cod 20664 14740 South Cuckold Creek Road, Newburg, Maryland 19a. Informant's Name/Reletionship (Type, Print) Robertino M. Smoth Method of Disposition

| 20b. Place of Disposition (Neme of Burial 2 | Cremation 3 | Removal from State | Holy | Cemetery | 8-5-99 MARY 20c. Location - City or Town, State 20e. Method of Disposition 4 ☐ Donetion 5 ☐ Other (Specify) Newburg, Maryland 22. Name and Address of Facility Sterling Funeral Service Funeral Service 1601 Kenilworth Avenue, N.E., Washington DC 20019 dise e, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final /Medical SEPSIS diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner SEVERE DEHYDR ATION physician and the burief-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequença of) INFARCT Division of Vital Records, P.O. Box 68760, ACUTE MYOCARDIAL Due to (or es a consequence of): 80 USB 23b. Did tobacco use contribute to the cause of death? signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of death? should I Completed 24e. Wes an autopsy performed? certificete hes birector, page 2 s 1□ Yes 2 No 1 Yes 2 No or Attending Physicien: director. Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 9 1 Yes 2€ No 1 Inpatient 2 ER/Outpelient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No deeth. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dev. Year) 29c. License number 29b. Signeture and title of certifier Chen Lac M.) D054804 07/30/99 30. Name and address of person who completed cause of deeth (ftem 23a) (Type, Print)

Kevin K. Lee, MD Cenna Medical Center, 7C Post Office Rd. Waldorf, MD 20602

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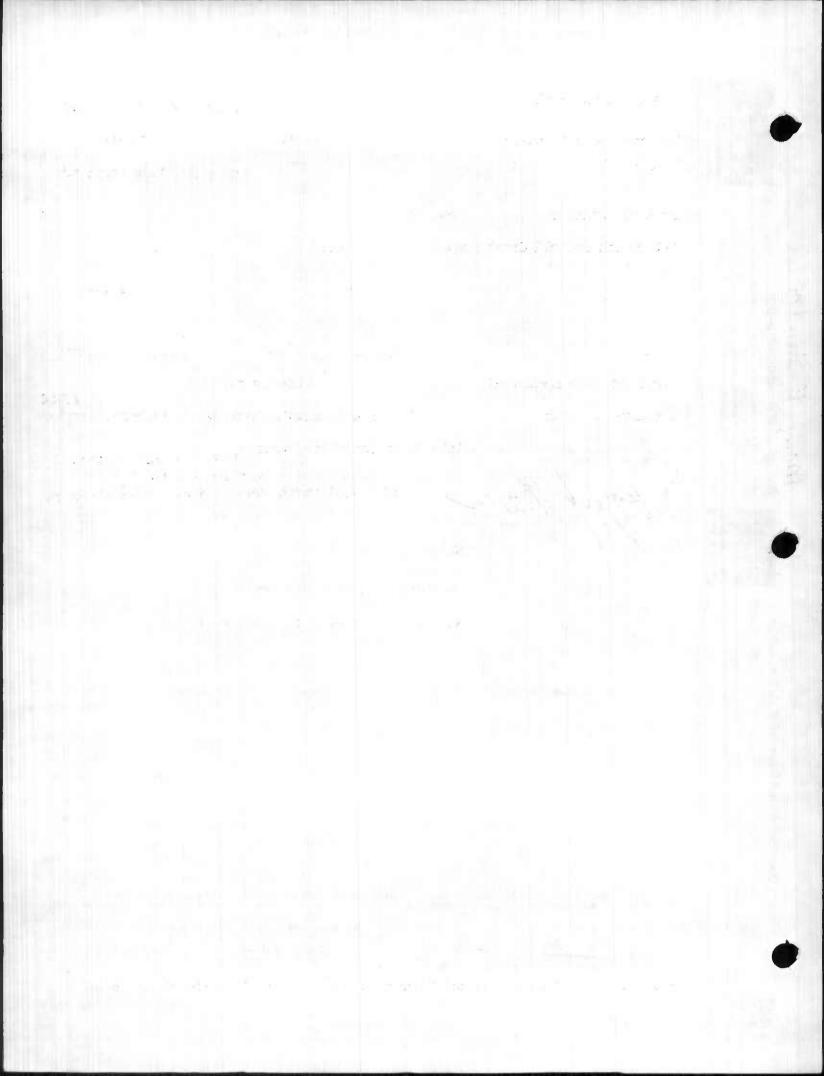
32. Registrer's Signeture

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 3 1990



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** STARKEY **GEORGE** THOMAS JULY 31, 1999 1040 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | PTILICE I...
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 5, 1938 Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country)
 MD **Funeral** 1 M 2 □ F 61 212 38 8080 Y_{rs} Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at Director MD Calvert Sunderland 1 ☐ Yes 2 🕱 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 6 6830 Den-Mar Lane 20689 USA Herns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural, or item only liquy or other treumatic event, the Medical Exercises 1 Yes 2 No If Yes, Give 1956-76 Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) project manager computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Thomas Starkey, Sr. Jennie Matson Martroni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Starkey/wife same as 10 above 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Buriai 2 □ Cremetion 3 □ Ramoval from State Ft. Lincoln Cemetery 8-3-99 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fuperal Service Liceoger 22. Name and Address of Fecility Rausch Funeral Home, Owings, MD P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, blastoma Physician/Medical Due to (or as a consequence of attending p Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Mnpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28d. Describa how Injury occurred 28b. Time of 28c. injury at Work? Affer 1 Neturei 2 Accident 5 Pending Investigation death. To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) 31 D52192 10 iddress of person who completed cause of deeth (item 23a) (Type, Print) 1 VA OKEEFE WM.D., PRINCE FREDERICK, 20678 JULIE A.

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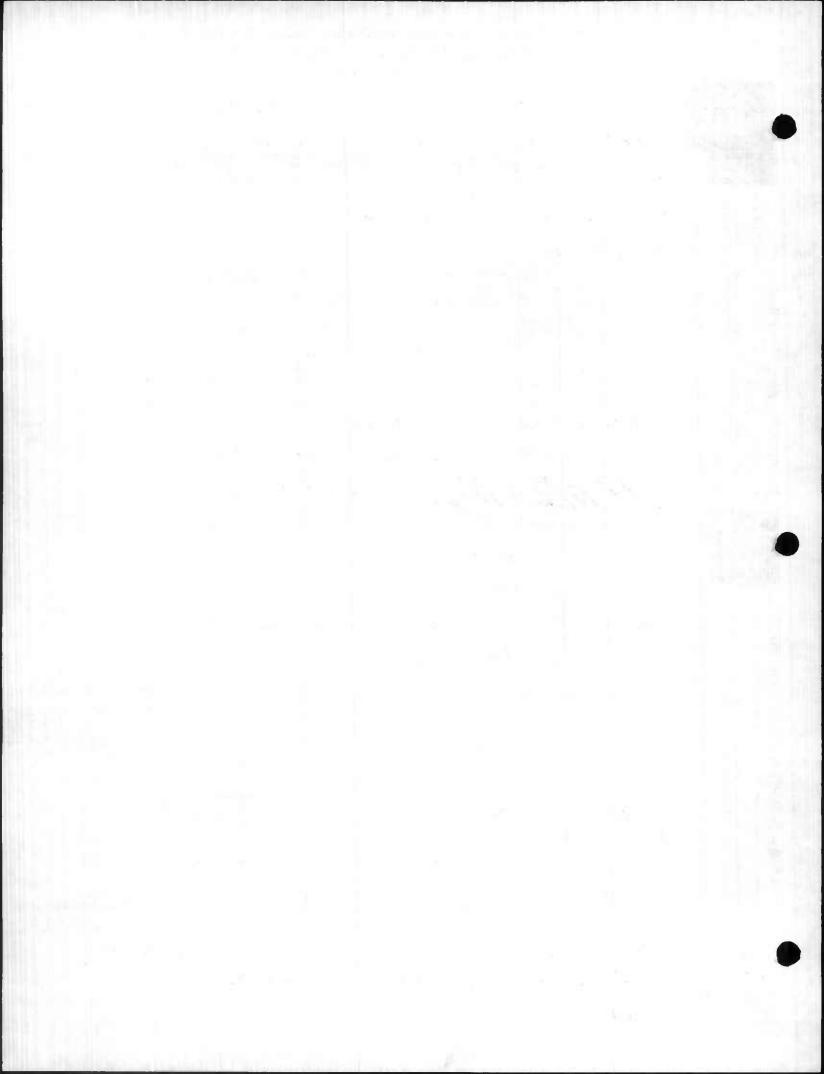
State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 3 1999

32. Registrer's Signature



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month AUG. 4 1999 8:10 P.M. HELEN **JEAN** STEVENSON 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) 14574 FOLTZ EDEN SOMERSET DR. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) MAY 2, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2□ F Months Days Hours Min MARY LAND Yrs. 72 213-24-1371 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No SALISBURY WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. RIVERSIDE APT. 115 A 21801 1514 DR. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Merital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates; 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOMEMAKER 18. Mother's Neme (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) WILBUR **ADAMS** NELLIE **JENKINS** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5963 RIDGESPRING CIRCLE SALISBURY, MD 21801 MORRIS T. STEVENSON, JR.-SON 20b. Placa of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burlal 2 ☐ Cremation 3 ☐ Removal from State 8-9-99 4 ☐ Donetion 5 ☐ Other (Specify) OLIVET EDEN, MD CEMETERY 22. Name and Address of Fecility 705 E. MAIN ST. CF5P SALISBURY,MD 21804 BOUNDS FUNERAL HOME, INC. BOUNDS FUNERAL HOME, INC.

23a. Part1. Enter the disease, or complications that based this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth (ancer Vancreebre Immediate Cause (Final disease or condition resulting in deeth) 3000 Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of). Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown COPD

Physician /Medical Examiner

that the death certificate be executed

o

Division of Vital Records,

other t

Department o Important: If any injury or Injury or

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

p

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examiner mant be notified at

Pages 1 and 2 should be filed within 72 hours after or ant of Health and Mental Hygiena. nt: If item 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0020

with the Maryland

death

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After this

s after death.

Hospital or Attending

sician and burial-transit physician s tha burial 603 signed by the a paga 2 s

Physician/Medicai 20 Completed Be

Examiner 2

director. funaral Certification: To the Hospital or Attervithin 24 hours after dar To the Funeral Director completely filled in by th

edical

3

4 Homicide 29a. Certifie

29b. Signature and file of

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Deeth

1 SNatural

2 Accident

3 Sulcide

Investigetion 6 Could not be determined

28a. Dete of Injury (Month, Day Year) 5 Pending

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 DOther (Specify DANGHTER S 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

24a. Wes en eutopsy

1 ☐ Yes 2 ☑ No

Cordinate Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Empire On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Dey, Year)

199

24b. Were autopsy findings aveileble prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER SNYDER, M.D.

106 MILFORD ST., SUITE 201 SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year) AUG 0 5 1999



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29c. License number

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	State of Ma	aryland /						Mental Hyg	jiene 9	9	26911	
			Cer	tificate	e of	Death		R	eg. No.		_0 _ 1	
Decedent's Neme (First, Middle, Las	st)							2. Date of Dee Month	th _Dey	Yeer	3. Time of Deeth	
DONALD	E. SI	PECK						8	9	79	2030	
4e. Fecility Neme (If not in stitution, give						4b. City, To	wn, or L	ocation of Deeth	4c. Count	y of Death		
PENINSULA REGIO	ONAL MEDIC	AL CENT	CER				ISBU	RY	WI	COMI	CO	
5. Social Security Number 6. Security Number 1	ex 7. Agu M 2□ F	e (In yrs. lest bi		If Under 1	1 Year Deys		24 Hrs. Min.	8. Dete of Birth (Month, Dey	Year)	9. Birth	place (State or Foreign	
210-24-8833	EN WIZE F	67	Yrs.					APRIL 2	7, 193	PEN	NŚYLVANIA	
Usuel Residenca of Decedent 10a, Stete 10b. County		10c. City, Tow	n or Loc	ation							10d. Inside City Limits	
											1 □ Yes 2 No	
DELAWARE SUSSEX 10e. Street end Number		SELBY	V L L L	10f. Zip (Code				On Chines of	Man Co.		
									0g. Citizen of	what Col	intry?	
231 W. POND CIRC	LE 12. Wes Decedent I	Ever in II C	12 18		997		ala 2 /Ca	and Was as No	USA	. A.	inen fadina	
1 ☑ Never Married 2 ☐ Married	Armed Forces?		IS. VI	Yes, speci	fy Cub	an, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1	☐ Yes 2	X No	Specify:			Specil	y: II	HITE	
15. Decedent's Ed			. Decede	ent's Usuel	Occur	pation			16b. Kind of B			
(Specify only highest gree	de completed)		(Give k	ind of work O NOT use	done	during mos	t of work	ing	TOO, KING UI D	-Gan 1055/11	lodotty	
Elementery/Secondery (0-12)	College (1-4or 5	+)		EACHE					EDI	САТТ	ON	
17. Fether's Neme (First, Middle, Last)									EDUCATION ne (First, Middle, Maiden Sumeme)			
C. LEX	SPECK			THELMA A. HI						EMAN		
19e. Informent's Name/Reletionship (7		198	o. Meiling	Address	(Street			el Route Number			(p Code)	
THOMAS C. SPECK/B	ротигр							K, PENNS			7060	
Oe. Method of Disposition	KOTHEK	20b. Pleca o				MILL	CKEE		20c. Location	_		
1 XBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		RIVER		etory or oth			8	/17/99 I				
21. Signeyan of Funeral Service Licens						ess of Fecility		ME.SELBY	VILLE.	DE 1	19975	
23a. Pent. Enter the dissess, or comp shock, or heart feilure. List only of	plicetions that called	the deeth. Do)						_,		Approximete	
shock, or heart fellure. List only o	one ceuse on each lin	4.								ĺ	Intervel Between Onset end Deeth	
Immediate Cause (Finel	She Tel											
diseese or condition resulting in deeth)		Due to (or ava	aro	ce								
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Convention to the test and delease	b. Stewa	L M	ujoc		1	in	ja	elvin				
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	- 0	Due to (or as a	oprisequi	ence on:		1"	1	-1.	0.40	1		
Ceuse (Diseese or injury	a ar	Miss	les	OVR	2	Ma	N	diase	el			
resulting in deeth) Lest		Due to (or es e	consequ	ence ot):						1		
	d											
Part II. Other significant conditions co					use gn	ven in Pert I					to the cause of death	
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Cardio gen eschimic	card	comy	opo	hy				perform		a	vallable prior to ompletion of cause	
			0							Of	I deeth?	
				/				1 □ Ye	s 2500	1	☐ Yes 2☐ No	
					100		of Deet	h (Check only on	Θ)			
exeminer?		2 D EB/O	utpetient	3□ DOA	Oth	her: 4 Nu	ırsing Ho	me 5 Reside			ify)	
exeminer?	Hospitel: Designation											
	Hospitel: Inpaties 28e. Dete of Injur (Month, Dey	y 26b.	Time of Injury		c. Inju	ry et rk?		28d. Describe ho	w Injury occur	rea		
exeminer? 1 □ Yes 2 No 27. Menner of Deeth	28e. Dete of Injur (Month, Dey	y 26b.		M 28		ryet rk? IYes 2□		28d. Describe ho	w Injury occur	red		

29d. Date signed (Mongli, Day, Year)

Eastern Show An Salishung MO 21801

Dopartment of Health and Mental Hyglene. Important: If Nem 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 Baltimore, Maryland 2121 Donald Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

ဥ

Funeral

Director

the Maryla

29e. Certifier (Check only one)

Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detected for use as the burial-transit completely filled in by the funeral director, page 2 should be detected for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical Be Completed by Medical Certification: To

> 8 (IL) State Registrar

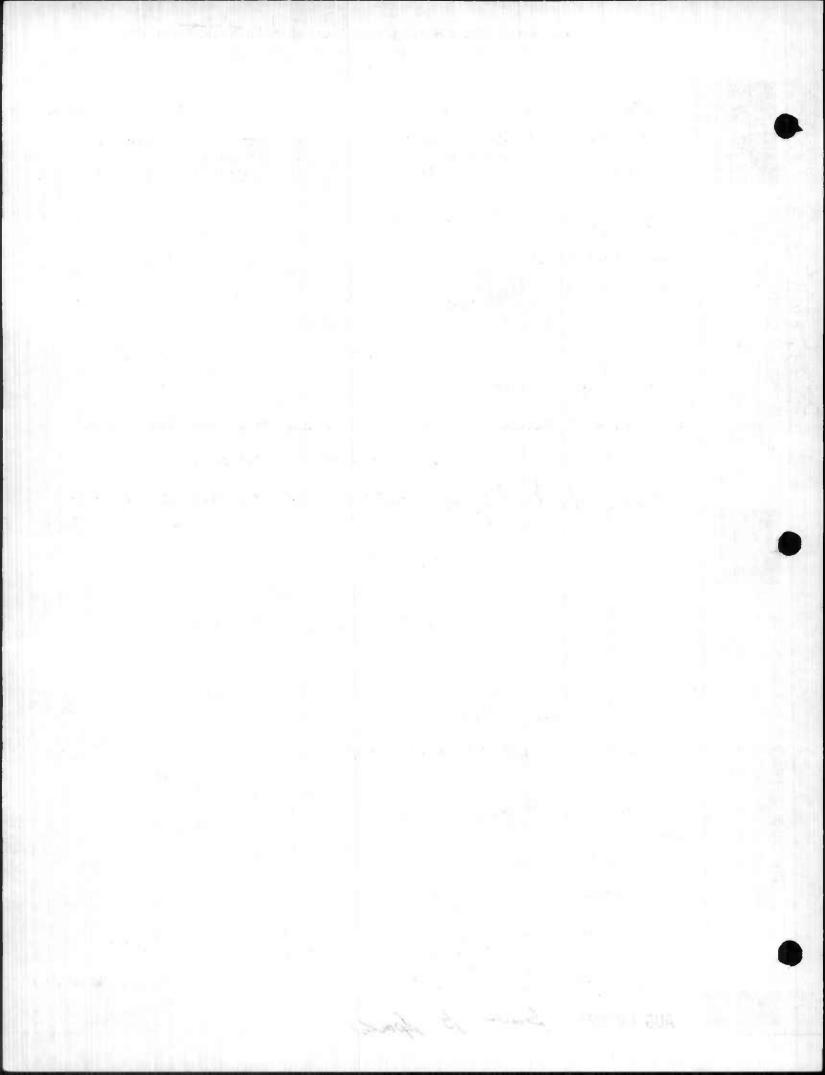
31. Dete filed (Month, Day, Yeer)

29b. Signeture end title of cartifier



30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95



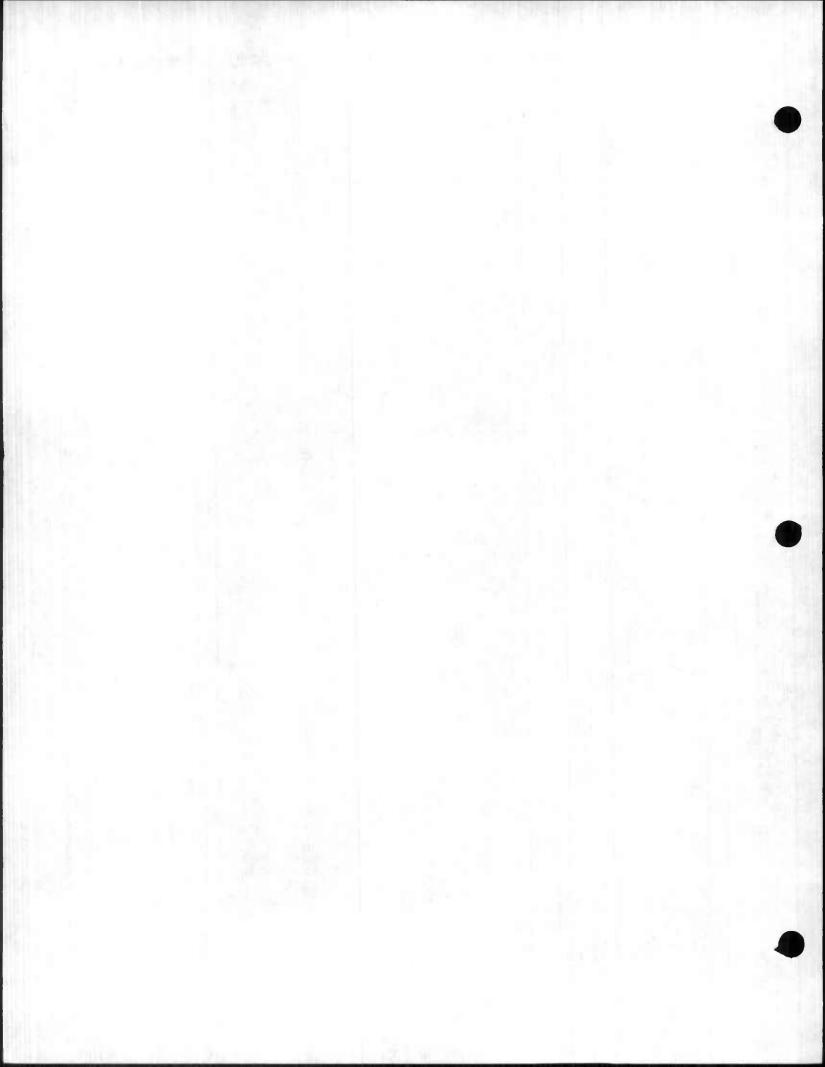
CERTIFICATE

26912

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CERTIFICATE M

26309



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State of Maryland / Department of Health and Mental Hygiene 9 26913

				Certific	cate of	Death	Re	g. No.					
	1. Decedent's Neme (First, Middle, Le	ist)						2. Dete of Deeth Month Dey Yee			Deeth		
nysician Modical	Dorothy	Co	ofer	S	taples	3	May 3,	1999	Yeer	6:15 I	PM		
Medical xaminer	4a Fecility Neme (If not institution, gir	ve street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth				
	Holy Cross Rehab	ilation Ce	enter			Burtonsv	ille	Mon	tgome	ry			
neral	5. Sociel Security Number 6.	Sex 7. A	ge (In yrs. lest	birthday) If U	nder 1 Yeer					ece (Stete or	Fore		
ector	224-09-4681 Usuel Residence of Decedent	1□M 200F	96	Yrs.	itis Deys	Figure Min.	Aug. 20	, 1902		INIA			
16	10e. Stete 10b. County		10c. City, To	own or Location					10	d. Inside City	y Limi		
to to	VA		Lyne	chburg						1 🗆 Yes	2] [] N		
drac must be notified Funeral Director	10e. Street and Number 113 Middlebore	n Place		10	f. Zip Code 24502	,	10	0g. Citizen of V USA		ry?			
era E	11. Meritel Status	12. Wes Deceden	t Ever in 11 S	13 Was F			necify Yes or No-		e - America	in Indian.			
P A	1 Never Married 2 Married 3 St Widowed 4 Divorced	Armed Forces 1 Yes 2 Hes, Give Yeer or Detes:	? INo	1U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: 11☐ Yes 2☒ No Specify: Specify: Whit									
	15. Decedent's E	ducation	16	16e. Decedent's Usuel Occupation 16b. Kind of Business/Indu									
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ToB	WILLIAM BU	RKS COFER				BERTA	PREAS						
	19e. Informent's Name/Relationship	(Type, Print)	1	9b. Melling Ad	dress (Street	end Number or Ri	ıral Route Number	City or Town,	Stete, Zip (Code)			
or other traumatic event, the Madical To Be Completed	GARY STAPLES	(SON)		1731 S	.W. 72	ND. AVEN	UE - PLAI	NTATION	, FLO	RTDA 1	333		
e dio	20e. Method of Disposition	(==-/	20b. Plece	of Disposition	(Neme of			20c. Location -			,,,,		
any injury or one	1 💢 Burlet 2 □ Cremetion 3 🖔 4 □ Donetion 5 □ Other (Speci		9	NGHILL	CEMET	ERY	5/6/99	LYNCHB	URG, V	VIRGIN	IA		
ODCO.	21. Signature of Europal Service Lice	nsee				ess of Fecility gel Funer	al Direc	tion, I	inc.				
				1091	Rocky	ville Pik	e Rockvi	11e, MD					
	23a. Pert1. Énter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betwee Onset and Death Consetted												
an													
cal	Immediate Ceuse (Final disease or condition	Renal Fa	ailure						3	Weeks			
ner	resulting in deeth) Pue to (or es e consequence of):												
<u>e</u>	Liver Failure b. Due to (or es e consequence of):												
Medical Examiner													
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edicai	that initiated events	C	Due to (or es	o (or es e consequence of):									
8	resulting in deeth) Lest		Due to (0: 03										
2		d											
Physician/							1 001 0111			***			
Ys	Pert II. Other significant conditions	contributing to death	but not resulting	g in the underly	ing cause gi	ven in Pert I.	23b. Did tobacco usa contribute to the cause of dea						
/ Physician/N	Depression, Deme	ntia, TIA					1 🗆 Y	es 2⊠ No	3 Prob	ably 4□l	Jnkno		
5							0.4 - 144		Jah Ma	re autopsy fi	in din o		
Completed							24e. Wes e perforr	n eutopsy ned?	9V9	pileble prior to	0		
pie									of d	leath?	1030		
E O							1 □ Ye	s 21 No	10	Yes 201	No		
0	25. Wes case referred to medical					26 Place of De	ath (Check only on	e)					
0	exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	0 C C C	Outpatient 3	DOA ON	hor:	lome 5 ☐ Reside		or (Consike				
	27. Menner of Deeth			b. Time of	JOON	45 ladising i	28d. Describe ho		, , , , ,	,			
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cal	2 Accident investigation 3 Suicide 6 Could not be					100 2 100	28f. Location (Street and Number or Rural Route Number,				har		
ŧ	4 ☐ Homicide determined	200. Piece of it	etc. (Specify)	, rarm, street, ta	ictory, office		City or Town		er or riurar	Hoole Hum	Jer,		
edical Ce		hysician: To the besi)		
Medical Cert	one)	end manner s	teted.	ond or invooring	Ottom, at 111y	opinion, dodin dod		ato one proof					
Σ	290, Signature and title of certifier				29c. Licen	se number	2	9d. Dete signe	d (Month, C	lay, Year)			
			N		0/32	2570	8 1	noo.	C-	1550	,		
	30. Name and address of person who	completed sauss of	doub (lion 22	a) (Type Brint)	LUUC	2005	-9	1 long	391	///			
	Danhna Hankin MT	2309 Sho	refield	Road I	Wheato	n, MD 20	902						
	Daphna Henkin, MD 2309 Shorefield Road Wheaton, MD 20902												
tate	31. Dete filed (Month, Day, Year)		trer's Signeture	1	1								

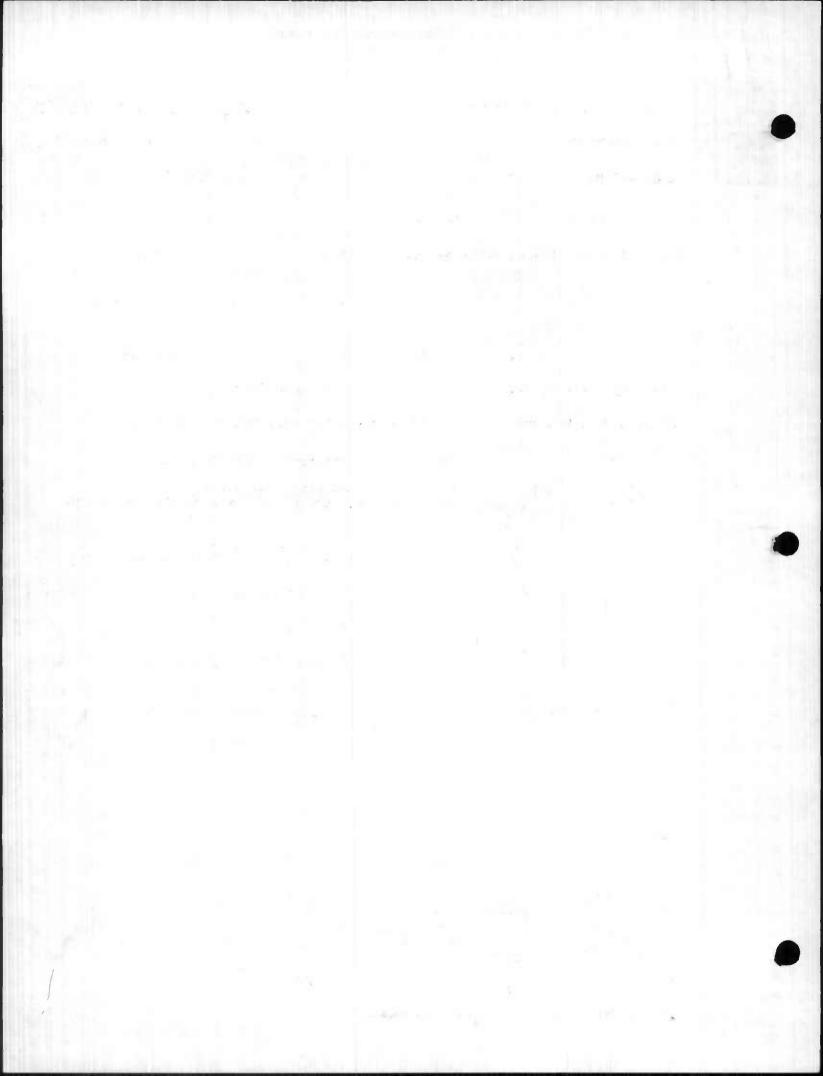
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State of Maryland / Department of Health and Mental Hygiene 9 9 269 14

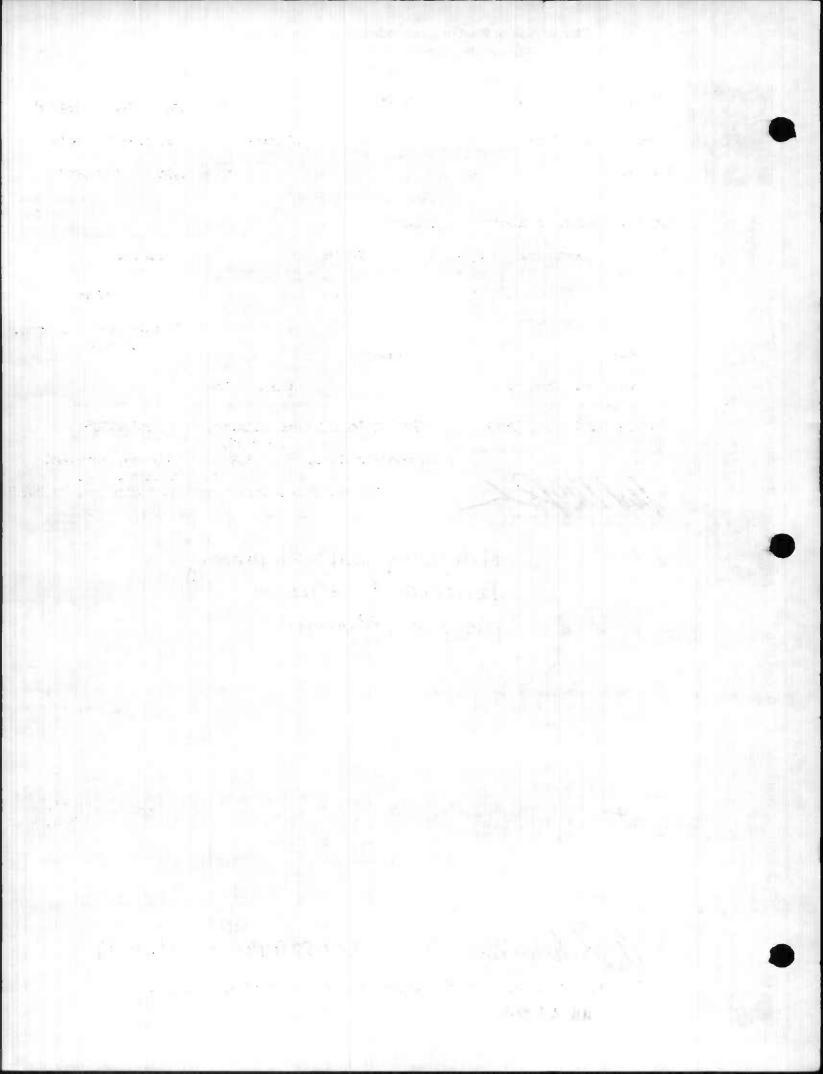
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Physic	an	1. Decedent's Nar							2. Dete of De Month	eath Dey	Yaar	3. Tima of Deeth		
/Medi				Sadie" Tho					August		1999	1430		
Exami	ner			give street end numb	er)				or Location of Dear		unty of Deeth			
	_ 4	Union H						Elkton,			il Cour			
Funeral Director							If Under 1 Year Months Dey			rth ay, Year) 1924		plece (Stete or Foreign ntry) PA		
show							ation					10d. Inside City Limits		
the Mary	tor	MD	Cecil		Elkto	n						1 ☐ Yas 2 No		
with the	Director	10e. Street end No		Drive, He	ritage W	oods	10f. Zip Code 2192				of Whet Cou	ntry?		
deeth w	Funeral	11. Meritel Status	chocone	12. Was Decede	ent Ever In U.S.	13. Wa	as Decedent of	Hispanic Origin?	(Specify Yas or No	USA scify Yas or No- 14. Race - Amarican Indian,				
72 hours efter deeth with the Maryland natural, or flems 23s or 28s-f show disal Examiner must be northed at	by	2.72=3131 = = 1.1-1.1	ried 2 Marrie	Armed Force	as?	111	Yes, specify Cu ☐ Yes 2 R	ıban, Mexicen, Pu	àrto Rican, etc.)		Bleck, White, ecify: White	etc.		
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d within giene. or than "r	du l	Elementary/Sec		Collaga (1-4				e during most of v red)						
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permit. Pag Department Important: any Injury		21. Signeture of F	unerei Service Li	Masse	Q	Spi	Name and Add	llikin F	uneral Ho	ome	DE	19720		
		23e. Pert1. Enter	the disease, or c	omplications that cau	sed the deeth. Do	not antar	tha mode of d	ying, such es card	iac or respiretory	orrest,	, DE	Approximete Intervel Between		
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/Medical		Immediete Ceuse diseese or conditie	(Finel	Clase	mic Co	mar	02A1	o Ho	art Fa	3 1/10	0-	Sypane		
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atter 1	Physician/	Death Other steel	et a constitution								0			
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that ned b	by P	D	ahe	Hen	Mel	er1	tus		_ 1	Yes 200	10 3 Pro	bably 4 Unknown		
v requires that the death cer been signed by the attendir should be deteched for use									24a. Wes	en eutopsy	24b. W	ere autopsy findings		
lew ree es bee	Completed								pen	ormed?	CO	allebia prior to empletion of cause deeth?		
The lew rate hes page 2	шо								1 🗆	Yes 2 LIN		□Yas 2□No		
Physicien: The lew requires the this certificate has been signed real director, page 2 should be to	BeC	25. Wes cese refe	rred to medical					28 Place of F	eeth (Check only					
Physicien: this certific rial director.	To B	exeminer?	110	Hospitel: 1 Inp	atient 2 ER/C	Outpetient	3 DOA	Whoe	Home 5 ☐ Res		Other /Specii	(v)		
g Phys er this neral di		27. Menner of Dee		28e. Dete of I (Month,		Tima of Injury	28c. Inj		28d. Describe			,,		
Attending for death. Ctor: After by the funer	atic	1 Neturel 2 Accident	5 Pending invastige	tion	Duy roury	injury		Yes 2□No						
f or Attending efter death. Director: After I in by the fune	Certification:	3 Sulcida 4 Homicide	6 Could no determin	ed 288. Piece of	Injury - At home, tetc. (Specify)	arm, stree	t, fectory, office	9		Street and N wn, State)	umber or Rure	al Route Number,		
ital or urs efte ral Dir lled in														
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9 269 15

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Day **Physician** July 26,1999 Marquerite P. Trainor 8:45 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 9518 White Pillar Terrace Gaithersburg Montgomery If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dafe of Birth (Month, Day, Year) **Funeral** Hours Months Days 1□M 2□F Yrs. 68 July 1, 1931 **Director** 109 24 9532 New York Usual Residence of Decedent the Meryland 10d. Inside City Limits 10a Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Forestville 1 Yes 2 No P.G. MD Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Innovatant: If them 27 is marked other than "natural", or thems 23a or 2 any injury or other traumatic event. 2616 Newglen Ave 20747 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marifal Stafus Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince George Community Elementary/Secondary (0-12) College (1-4or 5+) College 12 Office Manager 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Marguerite Williams Richard | Burns 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dawn Trainor-Fogleman (DAUGHTER) 9518 White Pillar Terrace, Gaithersburg, MD 20882 July 30 pate 99 20c. Location - City or Town, State 20b. Pleca of Disposition (Name of cematery, crematory or other place) 20a, Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July 30,1999 Clinton, Maryland 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service License Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsaf and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in deeth) Cardio pol mon any **Examiner** Due to (or as a consequence of): Examiner Paro tid Metastatic that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of): attending pt signed by the aid be detached f 23b. Did tobacco usa contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed complation of causa of death? page 2 s has 1 Yas 2 No certificete 1 Yas 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 28. Piece of Deeth (Check only one) Home Other: 4 Nursing Home 5 Residence 6 Other (Specify) Daughters To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? Certification: After 5 Pending investigation 1 Natural 2 Accident death. 1 Yes 2 No after deat 3 Sulcide 6 Could not be 281. Location (Straet and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, streef, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

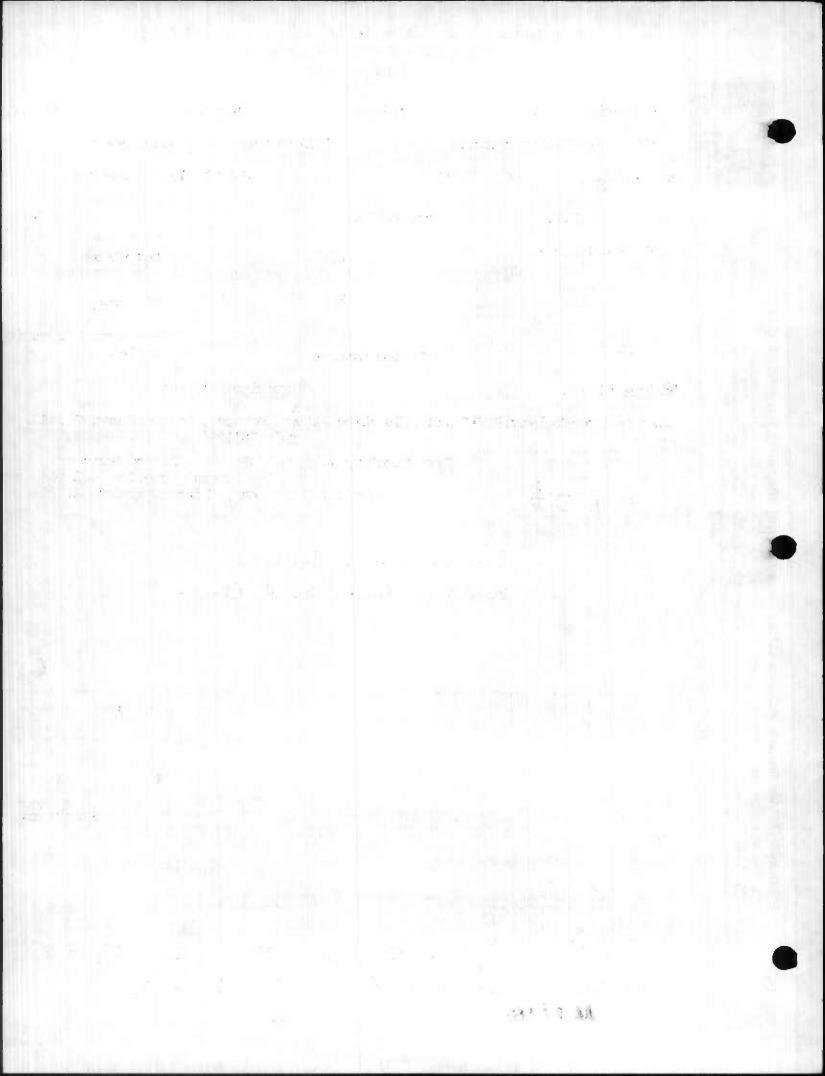
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) end menner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signatura and titla of certifiar olorado 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Vermeter W. 1075 32. Registraris Signatura State

DHMH 16 Rev 6/95

Registrar

1999

Dener



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month JOHN W. TRADER 08 07 99 1838 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. Hours Min. WICOMICO if Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, 9 Birthpiece (State of Foreign 1 2 M 2 □ F Months Deys Yrs. USual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 12 Yes 2 No ACCOMACK HORNTOWN 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 23395 1.0 BOX 10 bouRNe 115 M Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorcad Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

A.

17. Fether's Neme (First, Middle, Last)

1 Burial 2 ☐ Cremetion

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funerei Service Licensee

19e. Informant's Neme/Relationship (Type, Print)

Joseph

HILCEN

20e. Method of Disposition

Immediate Cause (Finel

1 Yes 2 No

1 Neturel

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29e. Certifier

disease or condition resulting in deeth)

Funeral

Director

"natural", or items 23a or 28a-f sho

the Medical

7 is marked other traumatic event,

or other 1

Department of important: if any injury or

by Funeral Director

Completed

Be

the Marylend

death

filed within 72 hours efter

Hygiene.

Pages 1 and 2 should be in nent of Heelth end Mental I

Heelth dem 27 i

21215-0020

Baltimore, Maryland

Examiner Physician/Medical þ Completed Be

be executed buriel-transi pue Box 68760. The law requires that the death certificate the 88 attending USB for P.O. signed by Records, 8 page 2 should certificate hes of Vital or Attending Physician: director. this in by the funeral After Division death.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in deeth) Lest 25. Wes case referred to medical exeminer? 27. Menner of Deeth

Certification: To within 24 hours after deat To the Funeral Director: Hospital Medicai completely

State Registrar

29b. Signeture end title of certifier DME m56 30. Neme and address of person who completed cause of deeth (Nem 23e) (Type, Print) JOHN T. BULKELEY, M.D. 31. Dete filed (Month, Day, Year) AUG 12 1999

5 Pending Investigation

6 Could not be determined

32. Registrar's Signeture

106 MILFORD STREET

boars

28c. Injury et Work?

1 ☐ Yes No

PNEUMONIA

IRADER

3 Removel from Stete

Due to (or es e consequence of):

23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

LABOR

3165 DAVIS

20b. Pieca of Disposition (Neme of cametery, cremetory or other piece)

Tabernasle BAPT Sthurch
22. Name and Address of Fecility

Due to (or es e consequence of):

Due to (or as e consequenca of):

1 Inpatient 2 □ ER/Outpetient 3 □ DOA

28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

injury

1100

Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f.

28a. Dete of Injury (Month, Dey Year)

P.O. BOX 104

7/6/98

FRACTURED ODONTOID AND C-1, TRANSIENT ISCHEMIC

ATTACK 1998, CORONARY ARTERY DISEASE

Hospitai:

24e. Wes en eutopsy performed?

24b. Were autopsy findings eveileble prior to completion of cause of death?

23b. Did tobacco use contribute to the cause of death?

2/2 No

1 Yes 2 No

3 Probably 4 Unknown

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 No

FALL AT HOME

Location (Street end Number or Rurel Route Number, City or Town, Stete)

HARMING

HANKI

HORN TOWN

917 W. ISAbellA St

SAlis. M7. 31801

20c. Location - City or Town, State

ete. Zip Code)

Approximete interval Between Onset and Deeth

Mother's Neme (First, Middle, Maiden Sumema)

Dete

hurch

HARlotte

new

19b. Meiling Address (Street end Number or Rural Route Number, City or Town,

HORNTOWN, VIRGINIA

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29d. Date signed (Month, Dey, Yeer)

29c. License number D0003599 8-9-99

SALISBURY, MARYLAND

21804

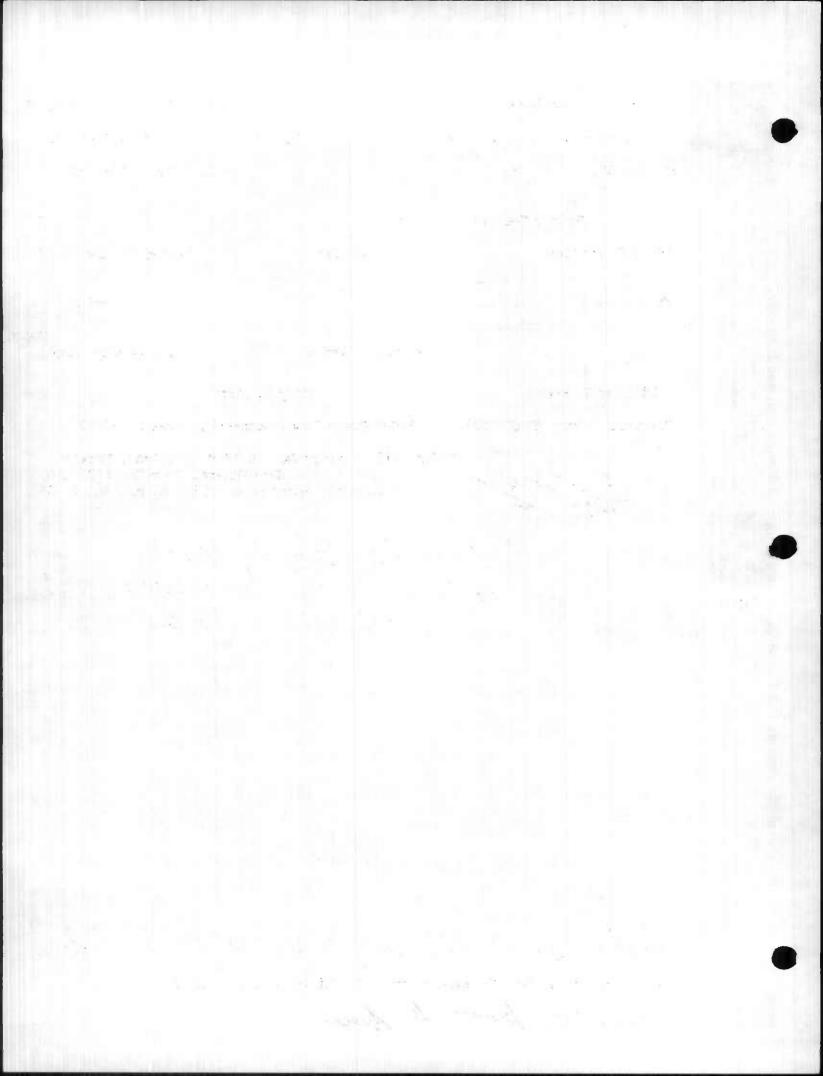
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State of Maryland / Department of Health and Mental Hygiene 9 9 269 18

							Ce	rtifica	te of	Death			Reg. No.			
	Physiciar	١	1. Decedent's Name (First, Midd Mary K		Leen	Taylo	r					2. Date of D Month Aug 6,	Dey	Year	3. Time of Death 3:38 AM	
	/Medica * Examine	_	4a Facility Name (If not institution Southern M	n, <i>give</i> :	street end n	ım <i>ber)</i>	TI E.			4b. City, To		ocation of Dee	th 4c. Coi	ince G	eorge's	
	Funeral Director		5. Sociel Security Number 229 – 09 – 6309	6. Sex		7. Age (In yrs. 80) If Und Months	er 1 Year Days			8. Date of B (Month, D May 2,		9. Birthp	place (State or Foreign of inia	
٠			Usuel Residence of Decedent 10a. State 10b. County	,		10c. Ci	ity, Town or L					ray 2,	1010		Od. Inside City Limits 1 Yes 2 No	
	from 23a or 28a-fall	חופכונ	MD Prince George's Accokeek 10e. Street and Number 10f. Zip Code 20607											of What Cour	ntry?	
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020	020 urs a urs a	2	11. Maritel Status 1 Never Married 2 Mar MX Widowed 4 Divorce	ried	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates:			Wes Dec If Yes, sp	2.20	an, Mexicar Specify:	gin? (S) n, Puerto	pecify Yes or N Rican, etc.)		Race - Americ Bleck, White, eclfy: Wi		
21215-0020	c . H	paraidi	15. Deceder (Specify only higher Elementary/Secondary (0-12)		ompleted,) (1-4or 5+)		B kind of w DO NOT	rork done use retire	during mos d)	t of won	king	16b. Kind o	of Business/Ind	dustry Board	
	be filed within tal Hygiena. d other then avent, tre M		7th 17. Father's Neme (First, Middle	Cafet	eteria Worker 18. Mother's Name (First, Mic							y School				
Maryland	2 should be filed and Mental Hygi is marked other aumatic avent, I		William J. Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of								M. er or Ru	1. Furr Rurel Route Number, City or Town, Stete, Zip Code)				
of Healt	00-2		Virginia Hulv 20a. Method of Disposition 12 Burial 2 Cremation	3 □R		20b.	Pleca of Disp cemetery, cre	osition (Nametory or	eme of other ple	ica)	1	cokeek, Dete	20c. Locati	on - City or To		
Baltimore,	permit. Page Department of Important: If any Injury or BRGS.		4 Donation 5 Other (2)		11		2	2. Neme	and Addre	ess of Facili	Lee	Funera	1 Home	,Inc 66	533 Old and 20735	
		1	23a. Part1. Enter the disease, a shock, or heart failure. Li	compli only or	cations thet	caused the dee					_			-	Approximete Interval Between Onset and Death	
1	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	8		eve	u (M	2.1	Mus	d	vaea	se	1	I well	
	Km and al-transit	/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1)	Que to (or as a corise	Tex	50	M	1	15/	den	Sia	72hr
x 68760,	ding physicia se as the bur		Cause (Disease or injury that initiated events resulting in deeth) Lest		l	Due to (s a conse	quence of):	cen		Ja	orai) (·)	
Bo	death of attenual for un	2										Data Di	10.0 /			
, P.O.	as that the death igned by the attento be detached for u.		Part II. Other significant conditi	ons con	tributing to d	leath but not re	sulting in the	underlying	cause gr	ven in Part			/		the cause of death? bably 4 Unknown	
of Vital Records,	been s should	Descen										24a. Wa	s en eutopsy lormed?	co	ere autopsy findings aiieble prior to impletion of cause death?	
tal Re	uclan: The law certilicata has rector, paga 2		25. Was case referred to medical	si .		,				DE Diese	of Dog	1 C	Yes 201	10 10	Yes 2□ No	
5	Physician: this certific ral director,		examiner?		lospitai:	Inpatient 2	ER/Outpetie	ent 3□ (Ot Ot	har:		ome 5 Res		Other (Specif	641	
	Phys raldi	•	27. Manger of Death		_	of Injury ofth, Dey Year)	28b. Time		28c. Inju Wo		Jising II		how injury or		<i>y</i> /	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After complately filled in by the funeral Madical Certification:	TIL CARLO	1 Naturel 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide	not be	28e. Plac	a of Injury - At I	Injury nome, farm, s	M treet, facto	1 🗆	irk?]Yes 2□	No		(Street and Nown, State)	um <i>ber or Rur</i> e	el Route Number,	
0	To the Hospital of within 24 hours af To the Funeral Di complataly filled in Medical Cas	D IDAI			er: On the t	e best of my kno pasis of examino										
	within To the compla		29b. Signature and the of centile	1	a A	A A	Timel	111	9c. Licens	se number	f C	3(29d. Date s	igned (Month,	Dey, Year)	
			30. Name and address of person Laxmi N. Ber						1 (1.	inter	/ >	vland 3	20735	6.	7/	
	State		31. Dete flied (Month, Day, Year			Registrer's Sign			1 (1.	LICOII	LICIL	y Lailu Z	.0733			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () () Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** WILLIAM PAUL THOMPSON August 8 1999 9:31 a.m. /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner North Beach, MD 718 Bayfront Avenue Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | July 10, 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Year) 1927 **Funeral** 1**⊠** M 2□ F 092 20 2027 Yrs. NY, NY Director 72 Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10e Stete 10h County 10c. City, Town or Location 7 is marked other than "natural", or frams 23s or 28s-f show traumatic event, the Medical Examiner must be notified as North Beach 1 ☐ Yes 2 1 No Anne Arundel Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20714 718 Bayfront Avenue IISA Funeral death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Bieck, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after or serment of Hastib and Mental Hygiane. ortant: If Item 27 Is marked other than "natural", or ites Injury or other traumatic event, fre Medical Examina 1 X Yes 2 No if Yes, Give Yeer or Detes: 1952–54 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: white þ 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) storeage 4 warehouse manager 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be William Joseph Thompson Dorothy 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Paul Thompson / brother 2525 Florida Blvd., # 333, Delray Beach, FL 33843 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremation 3 X Removel from Stete Department of Important: If any Injury or pace. 8-11-99 Woodlawn Cemetery Bronx, NY 4 Donetion 5 Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funerel Service Licensee Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Non-Hodgkin's Lymphouna Immediete Ceuse (Finel disease or condition resulting In deeth) /Medical 14ars Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Last Due to (or es a consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequença of): 88 esn 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes en eutopsy performed? completion of cause page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical exeminer? director Be 26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5 Residenca 8 □ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: After 5 Pending 1 RNaturel aftar daath. Olractor: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 2 4 | Homicide filled in 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely fi

IJA

30. Neme and eddress of person who completed cause of death (item 23a) (Type, Print) Bruce A. Silver, M.D.

Prince Frederick, MD 20678

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end pieca, end due to the cause(s) and menner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

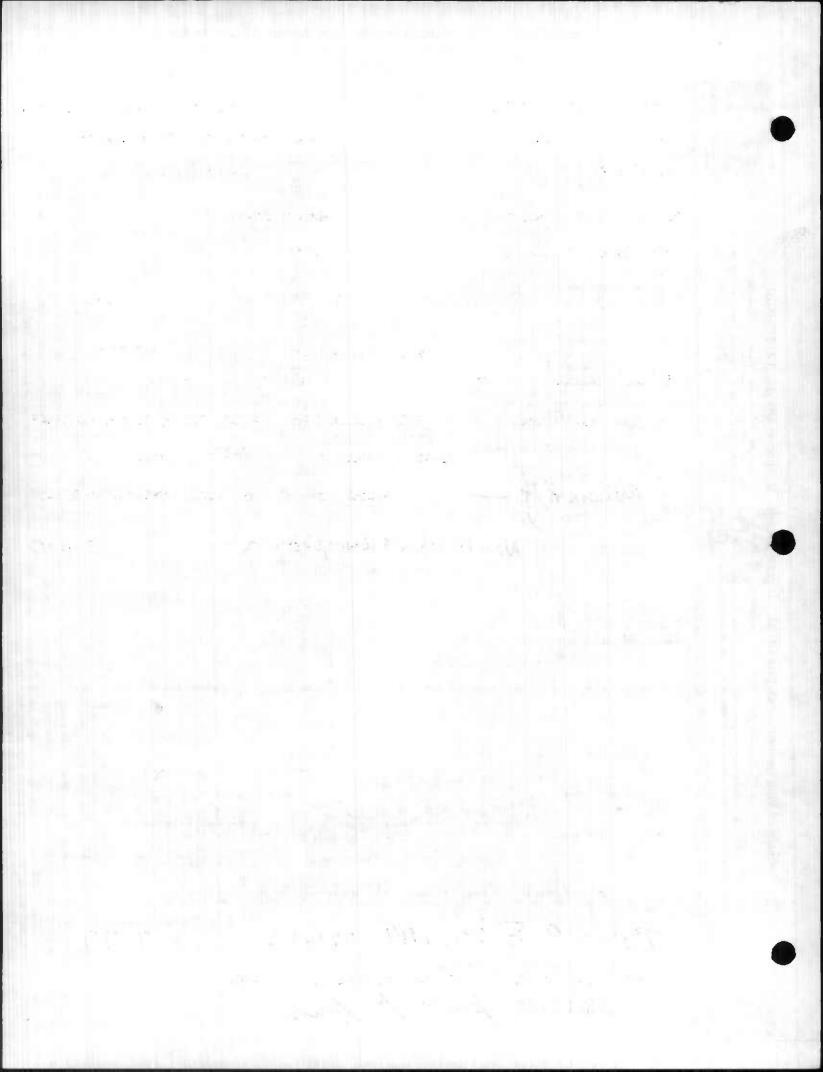
31. Dete filed (Month Dey, Year) AUG 1 1999

29b. Signature end title of cartifier

(Check only one)

32. Registrer's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene

					Certificate of	Death		Reg. No.	26920
		1. Decedent's Neme (First, Mid	dle, Last)				2. Date of De	eth	3. Time of Deeth
	Physician /Medical	Vernon Mil	ton Vermili	lion, Si	r.	A	Month		99 9:30 pm
	Examiner	4a Facility Name (If not instituti)		4b. City, Town, or Loc			The second secon
		110 Magnol:	ia Ave.			Pasadena	1	Anne A	Arundel
	Funeral Director	5. Social Security Number 214–20–7286	6. Sex 1⊠ M 2□ F	ge (In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, De		Birthplace (State or Foreign Country) MD
	Pu a	Usuel Residence of Decedent 10a. State 10b. Coun	N	10c. City, Town	or Location				10d. Inside City Limits
	OUZU hours after death with the Maryland unst; or items 23s or 28s-f show is Examiner must be notified at id by Funeral Director	MD Anne	Arundel	Pasade	ena		H - 2 1	1 ☐ Yes 2 ₺ No	
		10e. Street and Number 110 Magnolia	Ave.		10f. Zip Code 21122			10g. Citizen of Wha	
21215-0020		11. Marital Stetus 1 Never Merried 2 Never Me	If Yas Giva	? I No	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	cify Yes or No lican, etc.)	Bleck, \	American Indian, White, etc. White	
5-0	"netural",		ent's Education lest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of workin	g	16b. Kind of Busin	ess/Industry
121	led within 72 ho ygiene. Ner than "neturn rt, tre Medical Completed	Elementary/Secondary (0-12)	T		life. DO NOT use retired)			Machinis	
		12 17. Father's Neme (First, Middle	e (ast)		Mill Wright	18. Mother's Nama	/First Middle		
Maryiand	Mental H Mental H arked off arkc aver	Pellmon Vermi				Evelyn			
Mar 12 sho 1 and 1 1 m	19e. Informant's Neme/Reletion			Mailing Address (Street				ite, Zip Code)	
	tealth m 27	Anna Mae Verm. 20a. Method of Disposition	illion/wire		10 Magnolia Disposition (Name of	Ave. Pasa	Dete Dete	MD 21122 20c. Location - Cit	u or Town State
Baltimore	artment of a ortant: If he injury or of	15 Burial 25 Cremation	3 Permoval from State (Specify)	cemeter	y, cremetory or other ple Haven Ceme		ug 13	Glen Bu	
Balt	Departit.	21. Signatura of Funeral Service	o Licensed	~~~	22. Name and Address Barranco	& Sons, P.A	A. Seve	erna Park	Funeral Home
		23a. Part1. Enter the disease.	or comparations that cause at only one cause on each	ed the death. Do n	495 GOV. I	Ritchie Hw ing, such as cardiac or			Approximate
N.	Physician	shock, or heart tailure. Li	at only one cause on each	1 / /		1/4.			Interval Between Onset and Death
	/Medicai	Immediate Cause (Final disease or condition resulting in death)		litus			104 eurs		
	Examiner	resulting in death)	Ark	Dus to locate of	hold Cac	dioversent	las L	regul	SVP9r1
	physician and sub-transits the burlal-transited edical Examin	Sequentially list conditions,	6-11-	40.000		11.00	13/		
60,	be ex ician burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· sep				sday)		
	\$ 0 a	rasulting in death) Last							
Вох	at the death cert d by the attendin etached for use Physician/N		d						t
	the death y the atten sched for u	Pert II. Other significant condit	tions contributing to death	but not resulting in	the underlying ceusa gi	iven in Pert I.	23b. Did	tobacco usa contri	buts to the cause of death?
٥.	es that the death cer igned by the attendir be detached for use by Physician/R						1 Yas 2 No 3 Probably 4 L		
ords	seen s nould							en autopsy ormed?	24b. Wara autopsy findings available prior to completion of cause of death?
Re	The law at a has b page 2 si						1□	Yes 2□No	1 □ Yes 2 2 No
	certificata rector, pag	25. Was casa referred to medic	cat			26. Place of Deeth			
<u>></u>	Physician: this certific ral director, TO Be (examiner? 1 Yes 2 No	Hospital:	ient 2 ER/Out	tpatient 3 DOA Ot	hor		dence 6 □Other	(Specify)
	her thi	27. Manner of Death 1 □ Neturet 5 □ Pend	28a. Data of In (Month, D		ima of 28c. Injury	ory at 2	8d. Describe	how injury occurred	
Sio	Attending in death. Sector: After by the fune lifecation	2 ☐ Accident inves	tigetion		M 10	Yes 2 No			
	tal or Attending P rs after death. al Director: After t ied in by the funera Certification:		mined 286. Place of II	njury - At home, fer dc. <i>(Specify)</i>	rm, street, factory, office	2	8f. Location (City or To		or Rural Route Number,
	To the Neeplal or Attending Physician: With 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Certifier 152 Certify (Check only one) 2 Medica	ing Physician: To the best Examiner: On the basis and manners	of examination and	, death occurred at the ti	ima, data and place, a opinion, death occurre	nd dua to the d at tha time,	cause(s) and mann- data end place, and	er as stated. I due to the cause(s)
	within To the comp	29b. Signeture end title of certif	ior // L		29c. Licen	se number		29d. Dete signed (I	Month, Day, Year)
		* Eller	sway 9	y	0 3	20014		08/10/	41
		Ellioff Gor	hary My	7845 0	Kulfrd	RI, G	en Bu	rale, in	d, 21061
	State Registrar	31. Dete filed (Month, Day, Year AUG 1 2		trar's Signatura	9. lan			f	

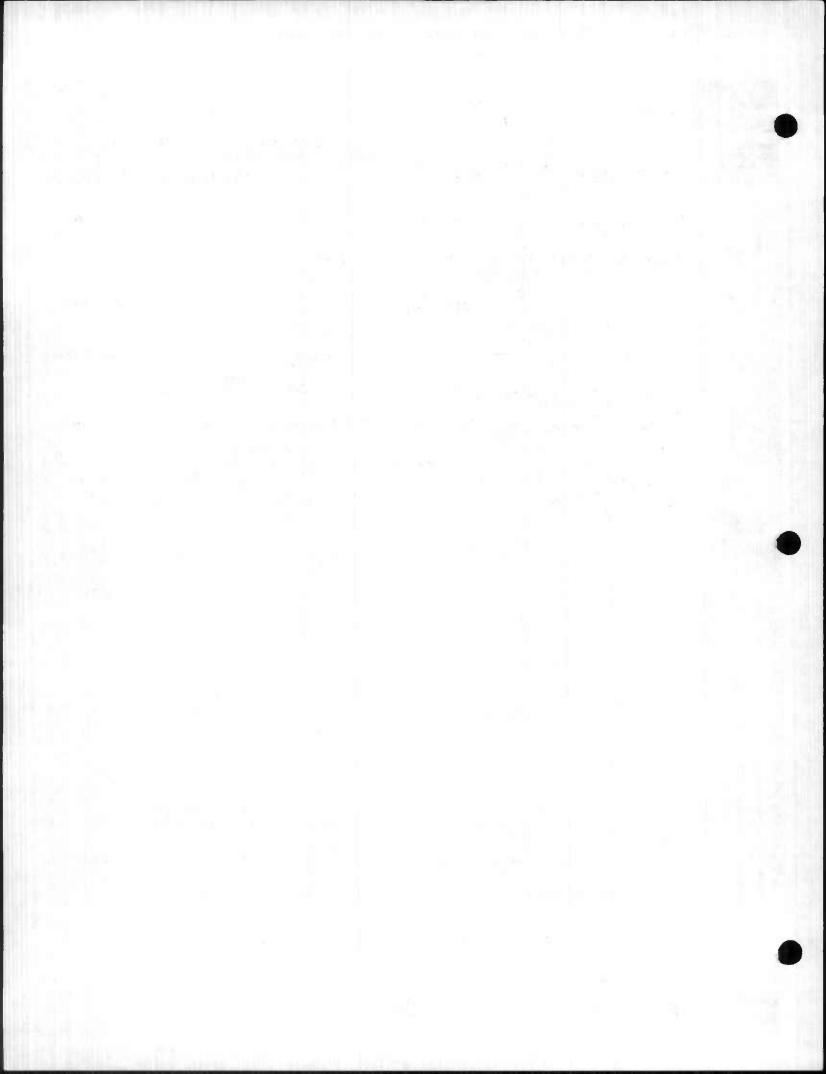
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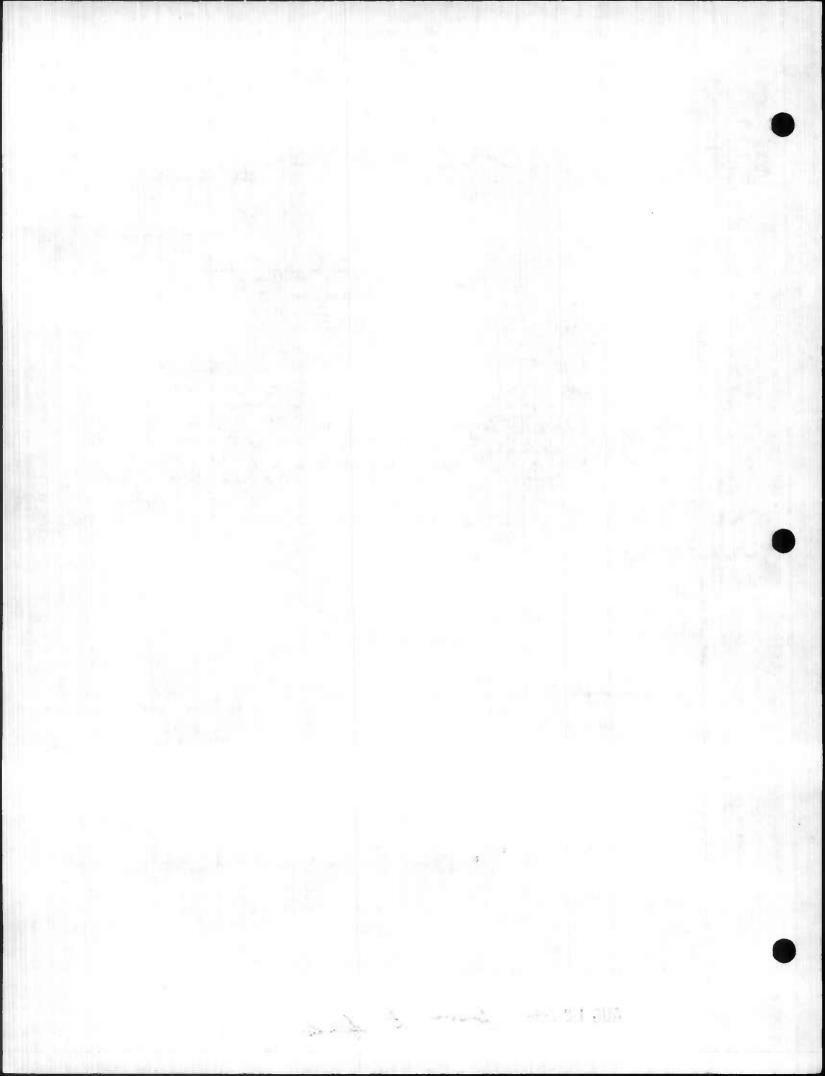
			Certificate of Death Reg. No.
	Dhuais		1. Decedent's Nama (First, Middla, Last) 2. Date of Death Amonth Day Yaar
	Physic /Medi		John H. Veasey, Jr. August 12 1999 1345
	Examir		4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death
			Union Hospital Elkton Cecil
	Funeral		5. Social Security Number 6. Sax 7. Aga (in yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Month, Day, Year) Country)
н	Director		216-38-383 / 58 118 May 14, 1941 Maryland
	pue *		Usual Rasidence of Decedant
	sho	5	Total mister City Limits
	Ne N	Director	Literal Elicitation
	E 0 8	눕	10é. Street and Number 10g. Citizan of Whet Country?
	23	gra	255 Hollings worth Manor 21921 USA
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral	11. Meritei Status 12. Was Dacedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc.
20	rs af	by F	1 Nevar Married 2 Merried 1 Nevar Married 2 Merried
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215	E	Completed	(Spacify only highest grada complated) (Give kind of work dona during most of working life. DO NOT use rating)
21	d within giene. r than "	E	Elemantery/Secondary (0-12) College (1-40r5+) Dry Wall Hanger Construction
pu	e filed al Hygi other vent, t	Be	17. Fathar's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Meidan Surnama)
/lai	Mental Mental arked c	To	John Henry Veasey, Sr. Betty Jane Spencer
lary	12 should h and Mer 7 is marks traumatic		19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Z	P 2		Barbara J. Veasey - wife 255 Hollingsworth Manor Elton, mo. 21921
ore	of He		20a. Mathod of Disposition 20b. Place of Disposition (Nema of camatary, cremetory or ofhar place) 20c. Location - City or Town, Stete
altimor	Pages nent of ant: If the ury or o		4 Donation 5 Other (Specify) Cherry Hill Methodist Cem. 1994 Cherry Hill MD.
alt	Depertment mportant any injury		21. Signatura of Funoral Sarvica Licansea 22. Name and Addrass of Facility Gee Fun eral Home
m	88 = 8		259 E. main St. Elkton, MO-21921
			23a. Part1. Entar the bisaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, Approximate
	Physician		Shock, or haart failure. List only one causa on each line. Interval Between Onset and Death
7	/Medical Examiner		Immedieta Cause (Final disease or condition rasulting in death) a. Seps 5- post-spession (Edap)
	LAGITITIE		Dua to (or as a consequence of):
Т	pe tis	Examiner	Tosencho pleural stump Fistula 6days
	end end	хап	Sequantially list conditions, if any, leeding to immadiata Dua to (or as a consequence of):
9	rtificate be executed ng physician end es the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or Injury that britishes weether the Company of the Property
68760	phys phys s the	edical	that initiated avants rasulting in daath) Last Dua to (or es e opnsequence of);
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Box	deeth ce e ettendii ed for use	clar	
o		Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death?
٣.			Caranna a Lund
of Vital Records,	requires seen sign hould be	d by	Dag a Glade 1 1 Case 0 0 24a. Was an autopsy 24b. Wara autopsy findings
00	- LU (7)	Completed	Jerry Vers out and Seane performed? eveilable prior to complation of cause
Re	hes hes	d E	of death?
Ø			1 Yas 2 DANO 1 Yas 2 No
₹		o Be	25. Wes casa referred to medical axaminer? 1 Yes 2 No Hospital:
	ding Phys h. After this funeral di): To	27. Mannar of Daath 28e. Deta of Injury 28b. Tima of 28c. injury et 28d. Describe how injury occurred
on	th. : Afte	to	1 Defural 5 Panding (Month, Day Year) Injury Work? 2 Accident investigation M 1 Year 2 No
Division	or Attending effer death. Director: After I in by the fune	III C	3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straet, factory, office 28f. Location (Street and Number or Rural Routa Number,
Ö	s effer	Certification:	4 Homlelda building, atc. (Spacify) City or Town, Steta)
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier (Check only Addical Examiner: On the best of my knowledge, deeth occurred at the time, data and place, end due to the cause(s) and manner as stated.
	in 24 he Fu he Fu	edical	(Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and manner steted.
	To the to the total	Σ	29b. Signetura and title of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year)
			Jayentica 1 tamp 1-2230 / 8/13/99
2	+IVA		30. Name and address of person who completed cause of deeth (Itam 23a) (Type, Print)
1	, , , ,		JAYANTILAL KYATELMI 1235INGERLY AVE ELKTON MI) 211921
	Sta Registr	_	31. Data filed (Month, Day, Year) AUG 1 6 1999 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 99 26922

Certificate of Death

	Certificate of Deat	th Reg. No.
	1. Decedent's Name , First, Middle, Last)	2. Deta of Death 3. Time of Death
Physician	Edna Venak	oles August 9, 1999 7:20 PM
/Medical Examiner	The state of the s	Town, or Location of Death 4c. County of Death
Examiner	Salisbury Center: Genesis ElderCare Sali	isbury, MD Wicomico
Funeral Director	219-05-3292 10 M 2EF 93 Yrs. Months Days Hour Usual Residence of Decedent	Jer 24 Hrs. 8. Deta of Birth (Month, Day, Year) DEC. 25, 1905 Mary Land
Pand Wand	10e. State 10b. County 10c. City, Town or Location	10d. Insida City Limits
with the Maryland a or 28e-f ehow the notified at	Mdi Wicamico Salisburg	1 ☐466 2 ☐ No
5 8 4	10e. Street and Number 10f. Zip Code 2/80/	10g. Citizen of What Country?
fer death from 23	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No- can, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, Whita, etc.
Dy by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	
5-0 2 ho	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
within then the the then the then the then the then then	(Specify only highest grade completed) (Give kind of work done during m life. DO NOT use retired)	
aryland 2 should be filed ad Mental Hygi marked other matic event, I	17. Father's Name (First, Middla, Last) 18. Mc	other's Neme (First, Middle, Maiden Surname)
Maryland de shuid be file the and Mental Hy 7 is marked oth treumatic event	1/6	UR DINELEH
should Ind Mening Mening Indiana		mber or Rural Route Number, City or Town, State, Zip Code)
Mar d 2 sh d 2 sh T is m treum	Plu Di () A SILL D'	
Health Health	EdNA Kuben Jack 1866 Dolls 20a. Method of Disposition (Name of	Dete 20c. Location - City or Town, State
Pages nent of Indian in y or or	1 Burial 2 Cremetion 3 Removel from State	18/1/2/
Lime . Pagiment lamt: Hamt: Ha	4 Donation 5 Other (Specify)	Em 1 199 HABERN Mide
Battimore, Incomit. Pages 1 and Department of Health Important: If Item 2 any Injury or other tonce.	21. Signature of Funeral Service Ucanase 22. Nama and Address of Fa	cility BENNIR South Jankens Nome
m 40239	517 y 85	abollo St Satisbaro md. 2180
Physician /Medical Examiner	shock, or heart feilura. List only one cause on each line. Immediate Cause (Finet disease or condition resulting in death) a. Due to (or as a consequence of):	Intervel Between Onset and Deeth
OX 68760, h certificate be assected anding physicien end use as the burial-transit in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as e consequence of): c. Due to (or as a consequence of):	
Bouth of the form		
cords, P.O. Box v requires that the death cert been aloned by the attending should be deteched for use leted by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	int t. 23b. Did lobecco use contribute to the cause of death? 1 Yes 2 146 3 Probably 4 Unknown
by be		
The law requires the has been signed page 2 should be Completed by		24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec		1 Yes 2 No 1 Yes 2 No
m: T	25. Was casa referred to medical 26 PI	aca of Death (Check only ona)
Of VItal Physician: The Physician: The certification and director, portal	axaminer? Hospitel: Other	
- × 00 -	27. Manner of Death 1 Death 5 Pending 28e. Data of Injury 28b. Time of Injury 4 Work?	Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred
Division of the Hospital or Attending Physibin 24 hours efter destinated by the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 5 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)
To the Hospital Within 24 hours To the Funeral completely filled Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the tima, date 2. Medical Examiner: On the best of axamination and/or investigation, in my opinion, one)	and place, end due to the cause(s) end menner as stated. Jeath occurred at the time, date end place, and due to the cause(s)
Me Me	29b. Signature and title of certifier 29c. License numb	er 29d. Data signed (Month, Day, Year)
8 4 8 4	1 2 10 000	2 00 0
	11 AMT 029	547 9/0/98
0	30. Name and address of person who completed causa of death (Item 23a) (Type, Print)	11 ///
7	William H. Robins, M.D. 1104 Healthway Dr. Sal	isbury, MD 21804
State Registrar	31. Date filed (Month, Day, Year) AUG 1 2 1999 32. Registrar's Signatura	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: #7 & #8 8/17/99 AACO mcq Certificate of Death HEALTH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** August 10 1999 5:25 pm James Donald White /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Future Care - Chesapeake Arnold Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Min. (Month, Day, Year) 5. Sociel Security Number 9. Birthplace (State or Foreign Country) Michigan **Funeral** 1⊠M 2□ F 377-28-7907 Director Usuei Residence of Decedent Mar death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28s-f show r le marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at MD Anne Arundel Arnold Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 854 Spriggs Court 21012 USA Herns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. should be filed within 72 hours after of Mental Hygiene.
marked other than "natural", or Net Amed Polices: 1 ⊠ Yes 2 □ No If Yes, Give 1 9 5 3 − Yeer or Detes: 9 5 3 − 1 9 5 5 1 Never Merried 27 Merried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Operations Manager Electric Supply Co. permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygi important: if them \$7 te marked other any Injury or other treum-street. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Jim White Agnes Barr 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ruth White/Wife 854 Spriggs Court Arnold, MD 21012 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 999 21. Signature of Fugeral Service Lices 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy Severna Park, MD 21146 Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiratory arrest, k, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Fine) DEMENTIA 3 YEARS disease or condition resulting in deeth) Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence ot): Physician/Medical Due to (or es e consequence ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yea 2 ☐ No Be 25. Was case reterred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 1 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending

P.O. Box 68760. Records, Division of Vital

State

Registrar

edicai

31. Dete tiled (Month, Day, Year) AUG 1 6 1999

29b. Signeture and title of certifier

Investigetion 6 Could not be determined

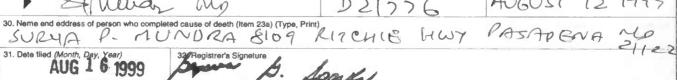
Melida

2 Accident

3 Suicide

29a, Certifier

4 Homicide



28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

AUG 2 8 1999 (Same) 2001 8 1 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JULIAN LAWRENCE WHITLOCK 09, 09:55PM 1999 August /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Perry Point VA Maryland Health Care System Cecil If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1⊠M 2□ F Yrs 218-18-3019 80 Director February 23, 1919 Maryland Usual Residence of Decedent JULIAN WHITLOCK 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Cecil North East 910 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be n 21901 United States Funerai 122 3rd Street, Red Point 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 No
If Yes, Give US Army
Year or Dates: 1941-1945 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 PHYSICIAN: Elementary/Secondary (0-12) Coilege (1-4or 5+) Automobile 12 Assembly Line Worker Manufacturer h and Martal Hygis 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Whitlock is maiden name should be nd Mental Julian Lee Whitlock Ethel Mae Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important. If them 27 is in any Injury or other traum 000.e. 2 122 3rd Street, Red Point, North East, MD Judith Whitlock / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 13 20c. Location - City or Town, State KNOWN 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State North East Methodist Cem, 1999 North East, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fuperal Soft 22. Name and Address of Facility Crouch Funeral Home NAME 127 South Main Street, North East, MD W 21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Severe pulmonary hypertension 4 years **Examiner** Due to (or as a consequence of): Physician/Medical Examiner Valvular heart disease 4 years death certificata be axecuted the attanding physician and ned for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o The law requiras that the signed by t 1 Yes 2 No 3 Probably 4 Unknown 0 Chronic obstructive pulmonary disease þ Division of Vital Records, 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy certificate has been s rector, page 2 should Completed page 1 Yes 2 No 1 TYes 2 No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 [ANatural Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending s after dea....ai Director: Afte 5 Pending investigation 1 TYes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Roufe Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ To the Hospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(a) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20215 August 09, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARMACHANDRA NAIR, M.D., VA Maryland Health Care System, Perry Point, MD

DHMH 16 Rev 6/95

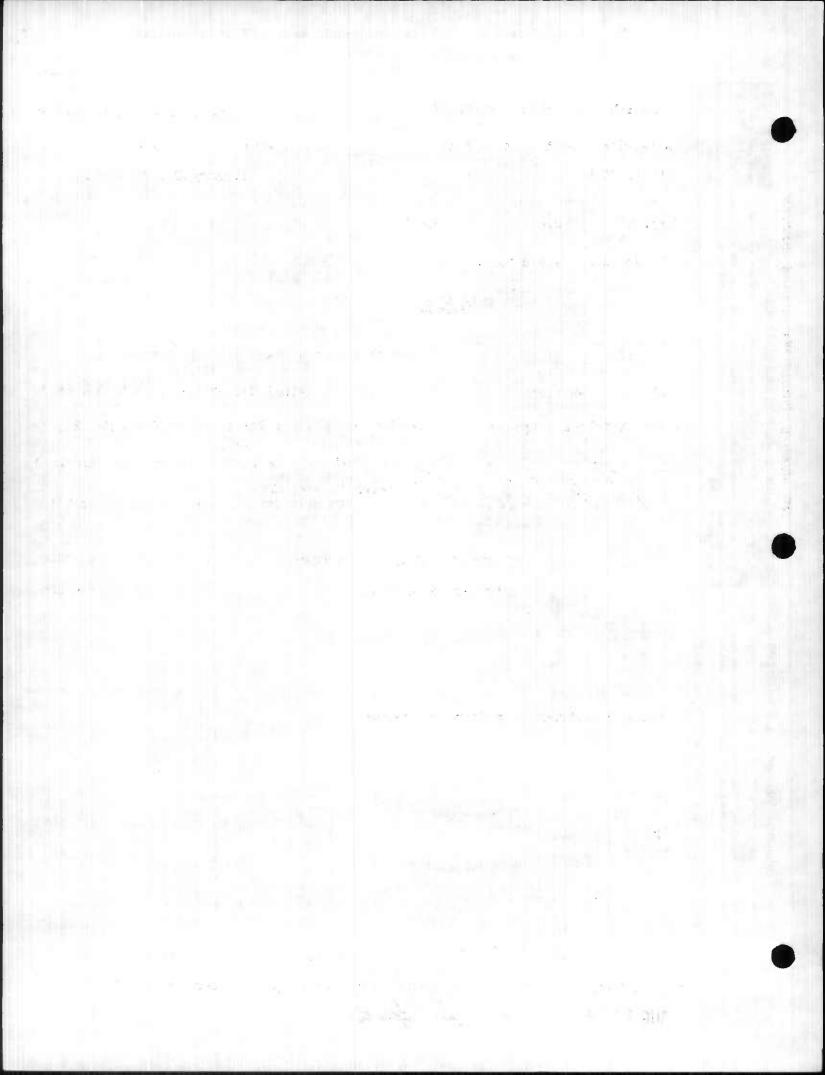
State

Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMEND: #23a-Part II, Certificate of Death mcq 8/12/99 AACO #28a,b,& e 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month Year **Physician** 3:00PM W. 8 1999 Marion August /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Annapolis

If Under 24 Hrs.

Min.

8. Date of Birth
(Month, Dey, Year) Ginger Cove Health Center Anne Arundel If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Days 1 M 2 F Yrs. 86 Jan. 8, 1912 Director Vermont 320-03-2039 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. State 10b. County r than "natural", or itams 23a or 28a-f shor the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 4000 River Crescent Drive 21401 United States Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Raca - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status ☐ Yes 2X No Yes, Give 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: specify: white Maryland 21215-0020 þ 3 Widowed 4 □ Divorced Yeer or Dates: "natural" Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene, other than Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) I 1 and 2 should be fit Health and Mental H tem 27 is marked off Be 2 Charles A. Webb Eva Rundell 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 nent of Health a ant: If New 27 Is 9005 Beatty Dr. Alexandria, Virginia Arlene Barnes (cousin) 22308 altimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete Ft. Lincoln Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 8/11/99 Brentwood, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funerel Service Licanse 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or amplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final respirator a rreals disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner ilmenses chronico certificate be executed physician and s the bunal-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Box 68760, Physician/Medicai Due to (or es e consequence of): 88 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. 2 1 Yes 2 No 3 Probably 4 2 Unknown NIA signed to Records, p 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Wes an eutopsy Completed peen page 2 1 Yes 2 No 1 TYPE 2 NO certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation 1 DNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homlcide N/A 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hose within 24 har To the Functional (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dev. Year) 29c. License number -11 Mehne Maris Sincle, Mg William 879199 D050514 Dassis 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Scrole, 2225F Defense + Iway. Hepre Hlaren criften, MD. 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

Registrar

AUG 1 2 1999

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 22,1999 3:00PM Wannall, Jr. William Howard /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17841 Clarke Road Piney Point St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 M 2□ F Months Days Hours 71 Yrs. Director 578 36 6678 Usual Rasidanca of Daceden May 1, 1928 Washington DC with the Marylend r 28a-f show a notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No P.G. Clinton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 10501 Dee Lane 20735 United States Pages 1 and 2 should be flied within 72 hours after death in nant of Heelth and Mental Hygiena.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumetic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣E No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Tes 2 No Specify: altimore, Maryland 21215-0020 Specify: by White XIX Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) General Supervisor PEPCO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Howard Wannall, Sr. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) William H. Wannall, III (SON) 6199 Seal Place , Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place July 27,1999 20a. Method of Disposition XX Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cemetery 21. Signeture of Funerel Servica Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line. Onset and Death **Physician** Immediate Causa (Final diseasa or condition resulting in death) /Medical Probable Myperredial Enfarction
Due to (or as a consequence of): 500 Examiner ARTERY DISEASE Examiner The law requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 980 Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate 25. Wes case refarred to madical axaminar?

1 Yes 2 No

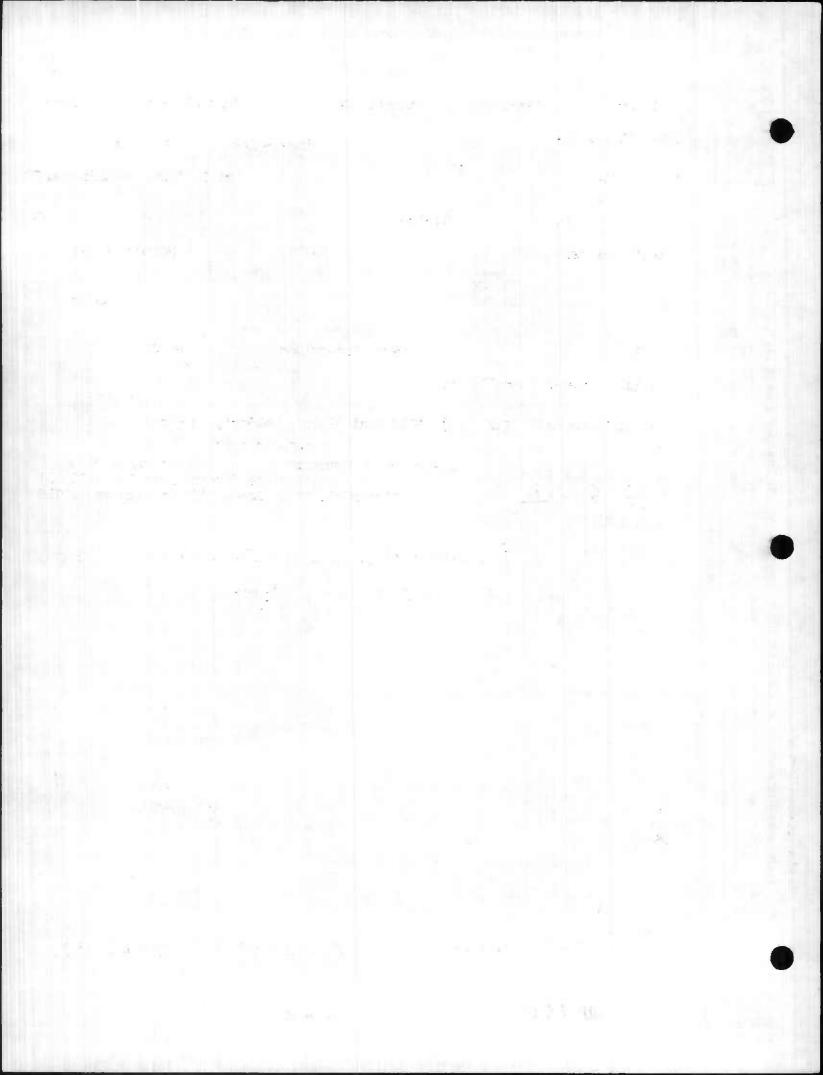
27. Manner of Death 26. Placa of Daath (Check only one)
Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify)
Injury at 28d. Describe how injury occurred or Attending Physician: Be Hospital Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No death. 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifles 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) 31. Da

32. Registr h's Signature

William Howard Wannall, Jr.



State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of	Death		Reg. No.	9 2	0921		
Physic	ian	Decedent's Neme (First, Middle, Les	st)					2. Dete of Dea Month	Dev	Year	3. Time of Death		
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Funeral Director			ex 7. Age (In yrs. lest birt 80	84	Deys	if Under 24 Hrs. Hours Min.	8. Dete of Birt Month, Da May 20	, Year 919	9. Birthpia Country Ma I	ce (Stete or Foreign land		
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filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itema 23a or 28a-f show bit, the Medical Examinet must be inclined at	by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:	er in U,S.		1 ☐ Yes 2 🕅 No Specify: Specify: B.				ck, White, etc	c.		
72 h	eted	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	16e.	Decedent's Usu	el Occup	petion during most of world)	cina	16b. Kind ot B	usiness/Indu	stry		
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ulth ar 11th ar 27 is r trau		Wilton Ward/Son	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		O. Box						oue)		
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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 3, 1999

4b. City, Town, or Location of Death

4c. County of Death Margaret Ellen Wilson /Medical 4:30 AM 4a Facility Name (If not institution, give street and number) Examiner Salisbury, Salisbury Center: Genesis ElderCare MD Wicomico Date of Birth (Month, Day, Year) JAN. 3,1916 Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2X F 83 Director 221-09-2088 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at V☐ Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 RUSSELL AVE 21801 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 72 hours after 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than 'netu any Injury or other traumatic exercises. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 SECRETARY HOSPITAL 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Surname) 8 ROBERT L. WILSON, SR. MARIAN E. MESSICK 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT E. WILSON, JR. MARDELA SPRINGS, MD P.O. BOX 154 21837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Buriel 2 □ Cremation 3 □ Removel from State MARDELA MEMORIAL CEMETERY 8/5/99 MARDELA SPRINGS, MD 4 Donation 5 DOther (Specify) Sérvice Licensee 22. Name and Address of Facility 705 E. MAIN ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. SALISBURY, MD 21804 Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner molaritation Examiner Lecomo Tron The law requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): physician is the burial Box 68760. Physician/Medical Due to (or es e consequence of): USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Jeno-Sas þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case reterred to medical examiner? 8 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Atter 5 Pending 1 Yes 2 No e Hospital or Attendit n 24 hours efter death. Ne Funeral Director: # pletely filled in by the f death. Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Medical C Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi

State Registrar

31. Date fited (Month, Day, Year) AUG 0 4 1999

(Check only one)

29b. Signature and the of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type Brint) 32. Registrar's Signature

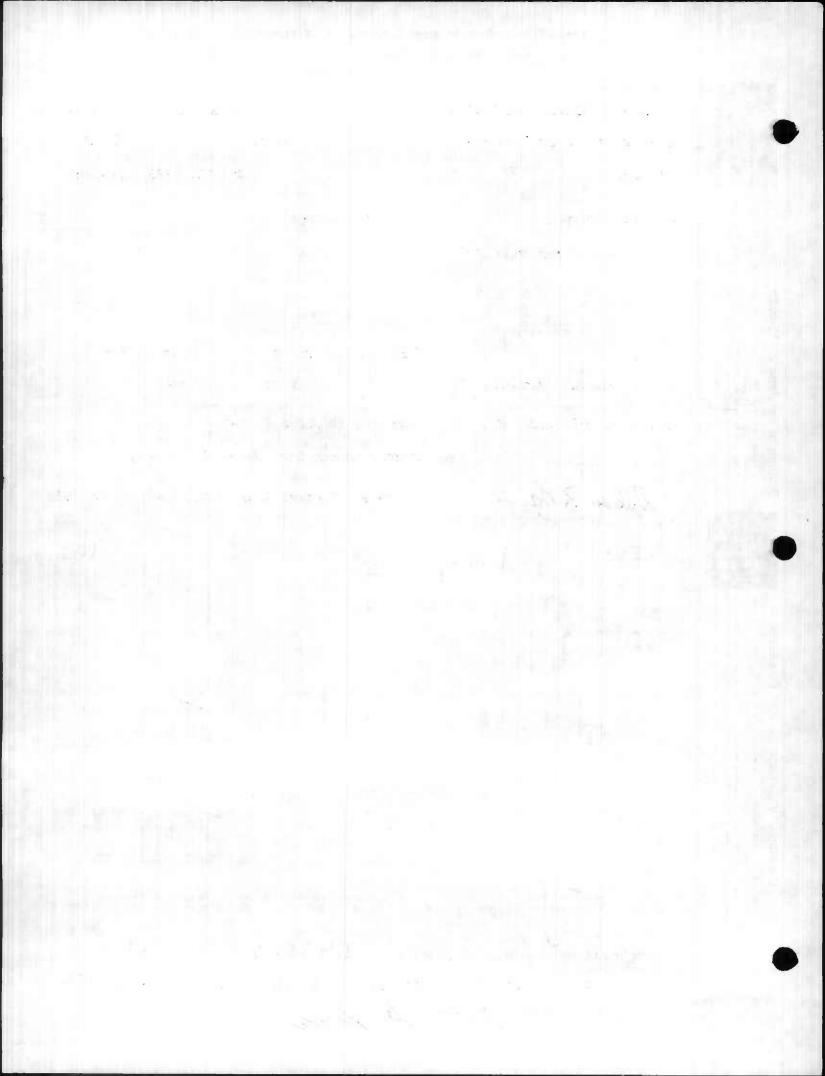
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dey **Physician** LINNAE COLLEEN WILKINSON 1999 11:25 p.m. August 6 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner 6905 Southern Maryland Blvd. Owings Calvert If Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthpleca (Stete or Foreign **Funeral** Months Deys Hours Min 1□M 20 F 73 Yrs. Jan 15, 1926 220 36 0002 Maryland Director Usuel Residence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Calvert Maryland Owings Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 6905 Southern Maryland Blvd. 20736 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritei Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) pernit. Pages 1 and 2 should be tilled within 72 to Department of Health and Merital Hygiene, importants if Itam 27 is merited other than 3 any Injury or other 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) bank administrator banking 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) 88 James Stanley Russell, Verna Boyd 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Orville A. Wilkinson, Sr. same as # 10 above 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20a Method of Disposition 1X Buriel 2 Cremetion 3 Removel from State 8-10-99 Mt. Harmony Church Cem. Owings, MD 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Licente 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 illiam K 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardled or respiratory errest, shock, or heart feilure. List only one cause on each line. intervel Between Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical 6 months unu cancer Examiner Due to or es e consequence of): Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 88 080 23b. Did tobacco use contribute to the cause of death? ed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 certificate has 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 mesidenca 6 Other (Specify) 1 Yes 2 No After this funeral 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Day Year) Attending 1 Naturel 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 6 24 hours a Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause(s) and menner as stated To the Hosp within 24 ho To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29c. License number 29d. Date sloned (Month, Dev. Year) 29b. Signature end title of certifier X mr 30. Neme and oddress of person who completed cause of deeth (Item 23e) (Type, Print) 12 un center Bluct Dunkylk, no 20154 T 1 1999 32. Registrer's Signeture State Registrar

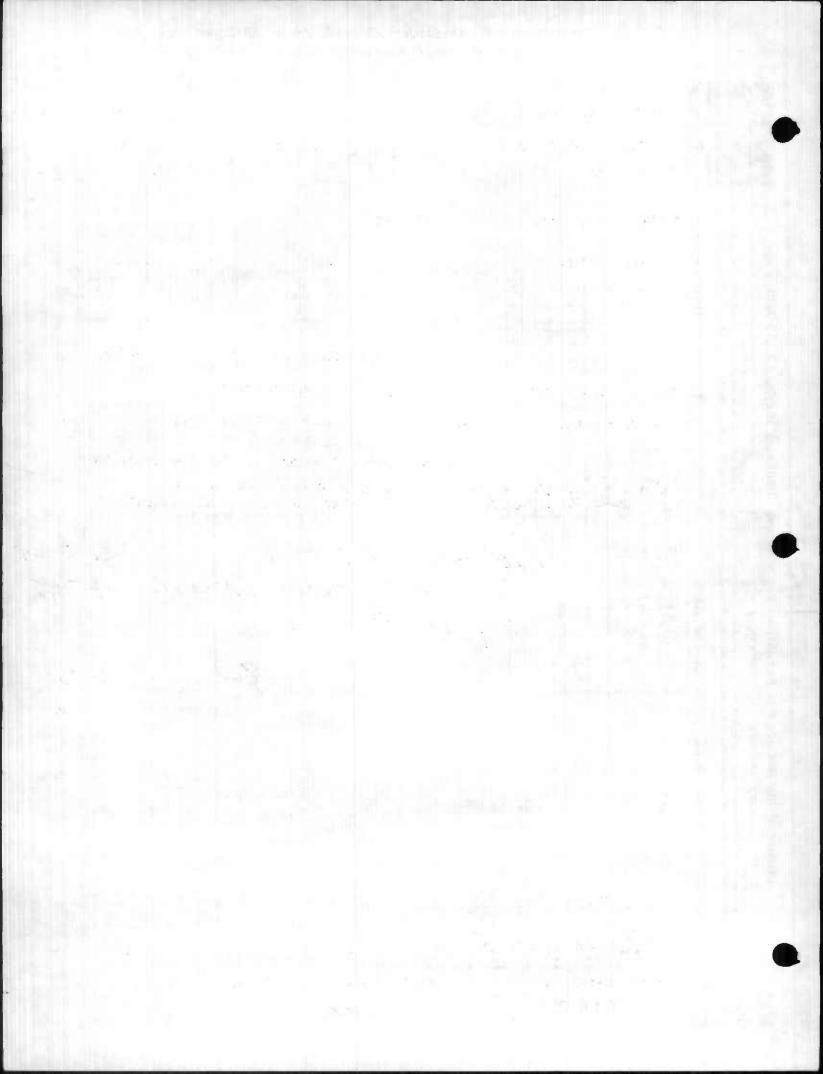
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State of Maryland / Department of Health and Mental Hygiene

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To B		CHARLES WILLI.	AM YO	UNG					ANNIE	STRAHIN			
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Medical Certification: 1	2 2 3	7. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide 19a. Certifier (Check only one) 19b. Signeture and title of certifier	stigation Id not be imined ying Physial Examir	28e. Place of building, ifclan: To the better: On the basis and manner mpleted ceuse of 219 S	Injury - At hetc. (Special States) of examinations stated.	Inju	e of ry M , street, fact eath occurrer Investigeti	ory, office and at the soon, in my egc. Licer D 24	Yes 2 No no no no no no no no no no	28f. Location City or To	(Street and Numi own, Stete) e cause(s) and m e, date and ptace,	enner as stated. and due to the cau	se(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month MG August 21, 1999 E. Margaret Bitzel 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 2673 West Park Drive Woodlawn BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days 1□M 2 F Hours Yrs. 94 212-01-1009 Dec. 8, 1904 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ZX No Baltimore Woodlawn Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2673 West Park Drive 21207 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 1 No Specify: 3 ☑Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home -0-Homemaker 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Sarah Davault William Schaefer 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21207 Mrs. Phyllis J. Rudd Daughter 2673 West Park Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removef from Stete 4 ☐ Donation 5 ☐ Other (Specify) Aug 27, Woodlawn, Maryland Lorraine Park Cemetery 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Segvice Licensee VINS 8728 Liberty Road Randallstown, Maryland 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death /2 Hh Immediate Cause (Finat disease or condition resulting in death) MYOCHNDIBL (NPM2 CMU) 1001 Due to (or as a consequence of): 5000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? NO No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes YONO 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed P.O. of Vitai Records,

Examine nding physician and use as the burial-transit Physician/Medical þ sate has been sig page 2 should b Completed cartificate has or Attanding Physician: funeral director, edical Certification: To Be After this

Physician

/Medical

Examiner

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Pages 1 and 2 should be fill ment of Health and Mental He ants If Hem 27 is marked oth lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other traumatic even lury or other lury even lury

Department of Important: If any injury or

Physician

/Medical

Examiner

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filed within 72 hours after

21215-0020

Baltimore, Maryland

Division after death.

Director: Aft
d in by the fur lilled in by 24 hours Hospital completely To the Within 2 To the

> State Registrar

29b.(Signature and title of certifier

4 Homicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

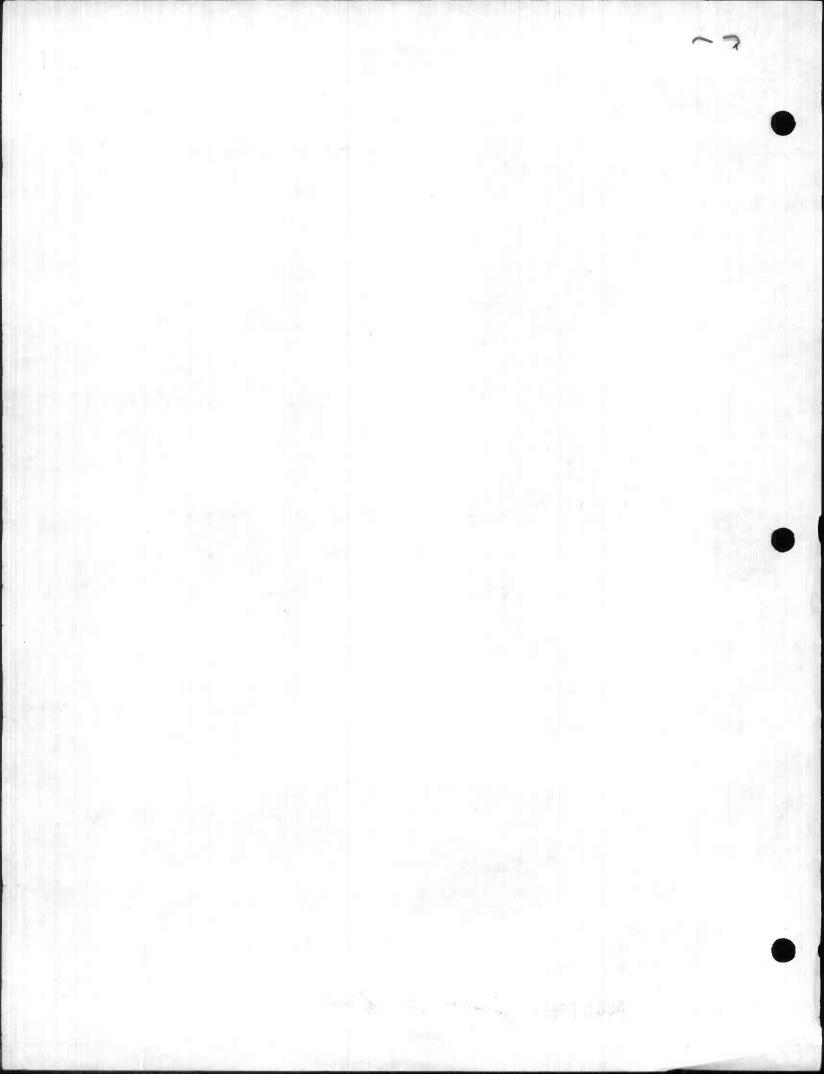
29c. License number 013557

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

5400 Old Court Rd Suite 204 RANDAUSTON, Nd 21133 MICHAEL PEARL MAN, MD 32. Registrar's Signature

DHMH 16 Ray 6/95

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month Day Yeer **Physician** Lois Angelo 24 1999 7:35 PM August /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 SF Months 96 Yrs. Director 220-36-6221 May 3, 1903 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or itema 23a or 28a-f ahow other traumatic avant, the Medical Examinar must be notified at Forest Hill, Maryland Harford Maryland 1 ☐ Yes 2 🖾 No Director 10f. Zip Code 21050 10e. Street and Number 10g. Citizen of What Country? 109 Forest Valley Drive United States Funeral death Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 3altimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2X No Specify: Specify P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic avant, the Mental Injury or other traumatic avant or oth Elementary/Secondary (0-12) College (1-4or 5+) 6th Domestic Different Homes 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3865 Colwyn Drive Jarriottsville, MD 21084 William Sellman Howser (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stets Druid Ridge Cemetery August 27, 1999 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signature of Funeral Se Mo0333 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Dementia years diseese or condition resulting in death) **Examiner** attending physicien and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): certificate be exec Box 68760, Physician/Medical Due to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Denknown Truct Infection Records, p 2 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? Anemia of Chronic Disense certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital after death.

Director: After this certifications 25. Was casa raferred to medical Be 26. Place of Death (Check only one) 1 Yes 2 ZING Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division 5 Panding Investigation 1 (Natural To the Hospital or Attandir within 24 hours after death. To the Funeral Director; Al completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be datemined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 | Homicide edical (1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 maD D35012 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 2 North Ave. Bel Air, Md. 21014 J. Kevin Lynch MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 27 bouch Registrar

DHMH 16 Rev 6/95

Joseph Jakas Marios

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

VERNON N. BAILEY AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G775 9-9-99 Wertificate of Death

Reg. No.

		Physic /Med Exami	ian ical iner
	F	unera	
Imore, Maryland 21215-0020	Pages 1 and 2 should be filed within 72 hours after death with the Manyland	ant if liem 27 is marked other than "natural", or items 23s or 28s-f show any or other treumstic event, the Hedges Examiner must be nottled at	To Be Completed by Funeral Director

Examiner

Physician/Medical

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Completed

Be

edicai Certification: To

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1226 PM Vernon N. Bailey AUGUST 21, 1999 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2300 MOUNT ROYAL TERRACE APARIMENT # BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months Maryland 1₽M 2□ F 36 213-78-1937 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Chesley Avenue 21206 U.S.A. 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give 1 ☑ Never Merried 2 ☐ Merried Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Uauel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Self Employed Auto Mechanic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Mary Patricia Kemp Vernon Elmer Bailey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3801 Chesley Avenue Baltimore, Maryland 21206 19e. Informent's Neme/Reletionship (Type, Print) Mary P. Bailey 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Suriel 2 ☐ Cremetion 3 ☐ Removel from State

Physician /Medical Examiner

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page 2 has

certificate

After this funeral

death.

within 24 hours after deat To the Funeral Director:

the Hospital

filled in by

complataly

and

The law requires that the death certificate be executed

Box 68760,

P.O.

of Vitai Records,

Division or Attending

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Immediate Cause (Final diseese or condition resulting in deeth)

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee

> a COCAINE, NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of)

Parkwood Cemetery

Due to (or es a consequence of):

28a. Perf 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, of been feilure. List only one cause on each line.

Due to (or as a consequence of)

1 🗆	Yes	2□ No	3 Probably	412 Unknown
24a. Wes	an ei	itopsy	24b. Were aut	opay findinga prior to

8/25/99 Baltimore, Maryland

22. Name and Address of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206

4b. Were autopay findings available prior to

Approximate Interval Between Onset and Deeth

1 Yes 2 | No completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical			
exeminer? NOXYes 2 No	Hospitel: 1 Inpatient	2 ☐ ER/Outpatient	3□ DOA
27 Manner of Death	28e Date of Injury	29h Time of	280

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Found: (Month, Dey Year) Found: -99 М

Injury at Work? 1 ☐ Yes X ☐ No 8-21-99 11:55

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred UNKNOWN

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 2300 MT. ROYAL TERRACE BALTIMORE, MD

23b. Did tobacco use contribute to the cause of death?

29e. Certifier (Check only one)

1 Netural

2 Accident

3 Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted.

**Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner steted.

29b. Signature and title of certifie

O.C.M.E.

29c. License number

29d. Dete signed (Month, Day, Year) AUGUST 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLACYDAND A. Koroh 31. Date filed (Month, Dey, Year)

5 Pending

investigation

6 Could not be

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrer's Signeture

FOUND: APARTMENT

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LANGE THE STATE OF THE STATE OF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gertificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day. Month Elsa E. Buhl AUGUST 23 1999 1030 AM 4a. Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Saint Joseph Medical Center Towson Baltimore 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M ZOKF 88 218-01-9353 June 11, 1911 Maryland Usual Residence of Decedant 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No Fullerton 10e. Street end Number 10a. Citizen of What Country? 10f. Zip Coda 20 W. Elm Avenue 21206 U.S.A. Was Decedent Evar in U.S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-lt Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yas 2 ☒ No It Yas, Giva Yaar or Dates: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Edward Wallut Ernestine Calal 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Thomas Buhl PO Box 1328 Hanover Pennsylvania 17331 20b. Place of Disposition (Nema of cematary, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State Parkwood Cemetery 8/26/99 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland 22. Nama and Addrass of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland Lead the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, Immediata Cause (Finel diseasa or condition rasulting in death) ENDOMETRIAL CANCER WITH METASTAES TO Due to (or as e consaguance of): URINARY BLADDER AND LIVER 6 MONTHS Due to (or es a consequance ot): MALNUTRITION DUE TO ENDOMETRIAL CANCER 6 MONTHS Dua to (or as e consequence ot) ISCHEMIC CARDIOMYOPATHY 3 YEARS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 20 No 1 Yas 2 No 1 Yes 26. Placa ot Deeth (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 1MInpatient 2□ ER/Outpatient 3□ DOA 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding

The law requires that the death certificate be executed pue physician er s the burial-t Division of Vital Records, P.O. Box 68760 certificate the Hospital or Attending Physician: thin 24 hours efter death. the Funeral Director: After this certifica mpletely filled in by the funeral director; i

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Mexical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death v Depertment of Health and Mentel Hygiene. Important: If if iem 27 is marked other than "natural". **** PAGES.****

Saquentially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disaasa or Injury that initiated events rasulting in daeth) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Wes casa rafarred to medical examinar? 1 Yes 2 No 27. Mannar of Daath 1 Netural 1 Yas 2 No 2 Accidant Invastigation 6 Could not ba 3 ☐ Suicide 28f. Location (Straat end Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the causa(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifian (Check only one) 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Dete signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in to

31. Data filed (Month, Day, Year)

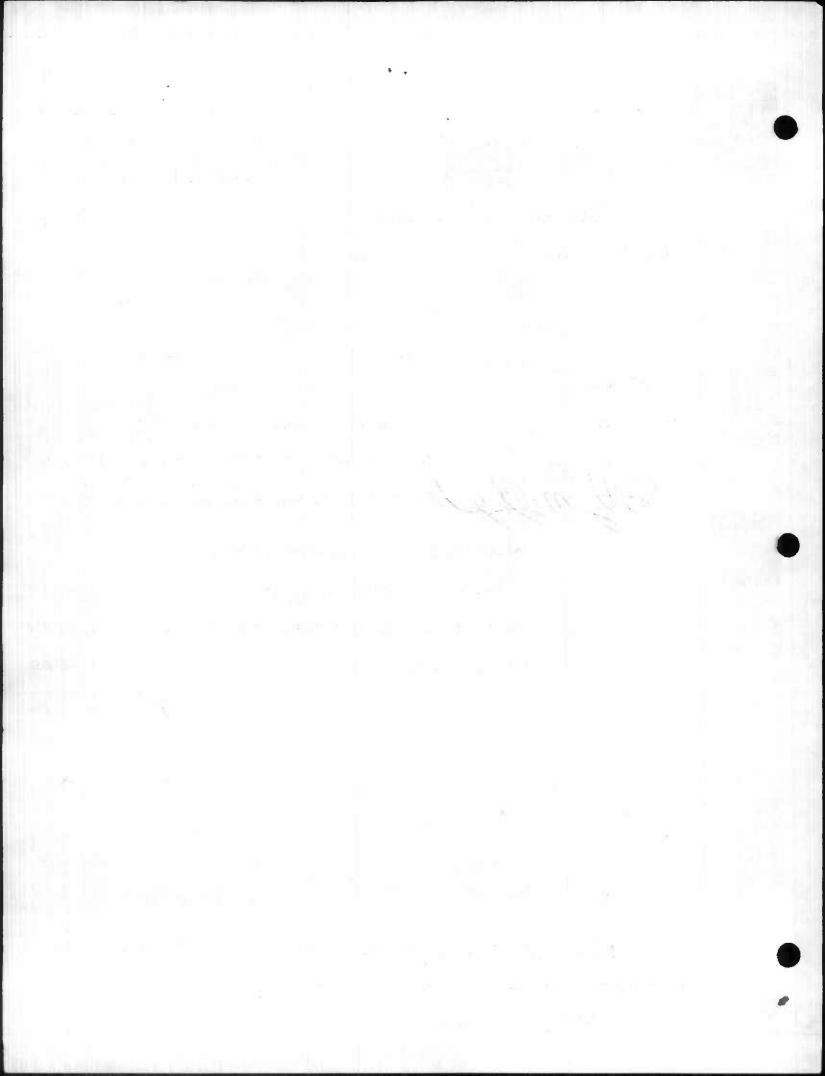
Mutinidad D. de Leon, M. W. D 19508

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Ragistrar's Signetura

I wa & Spark

NATIVIDAD D. DE LEON M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death 9 CHARLES 10:40 A.M RAY BEDNEGO August 25 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Franklin Square Hospital Kosedale If Under 24 Hrs. 8. Date Hours Min. Mo Baltimore Center 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar Months Days 5. Social Security Number . Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) 180 M 2□ F Yrs. 214 20 4854 73 1926 NORTH CAROLINA Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HARFORD **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 CROSSGATE AVENUE 21040 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Yeer or Detes: WW I Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - Amarican Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE WII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 REAL ESTATE AGENT REAL ESTATE 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) **FURMAN BEDNEGO** IDA HARTLEY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) FRANCES F. BEDNEGA / WIFE EDGEWOOD, MD 21040 Dete 20c. Location - City or Town, Stete 613 CROSSGATE AVENUE 20a. Method of Disposition Plece of Disposition (Neme of cematery, cremetory or other place) 1 Buriel 2 Cremetion 3 Removal Irom Stata OAKLAWN CEMETERY 8/28/99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licey 22. Name end Addrass of Fecility CVACH/ROSEDALÉ FUNERAL HOME 1211 CHESACO AVENUE MD 21237 BALTIMORE 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Finel Month diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of causa of death? Wes en autopsy performed? 1 Yes 204 No 1 ☐ Yes 2 ☐ No k only one)

Examiner The law requires that the death certificate be axecuted and the burial-trai Box 68760, USB BS P.O. ned by Division of Vital Records,

or Attanding Physician:

Hospital

death.

24 hours after deat Funeral Director:

within 2 To the I \$

Physician/Medical Completed by ate has been signe page 2 should be certificate Be Medical Certification: To this Affer

Physician

/Medical

Examiner

Director

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ednego, Charles Baltimore, Maryland 21215-0020

Mental)

Pages 1 and 2 should

Department of Health a Important: if them 27 is any Injury or other tra-

Physician /Medical

Status Post Pneumonectomy,	
Obesity, Hypertension	246
25. Was case referred to medicat 26 Place of 1	Deeth (Check

Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident

6 Could not be determined 3 Suicide 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

12 Certifying Phyetcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

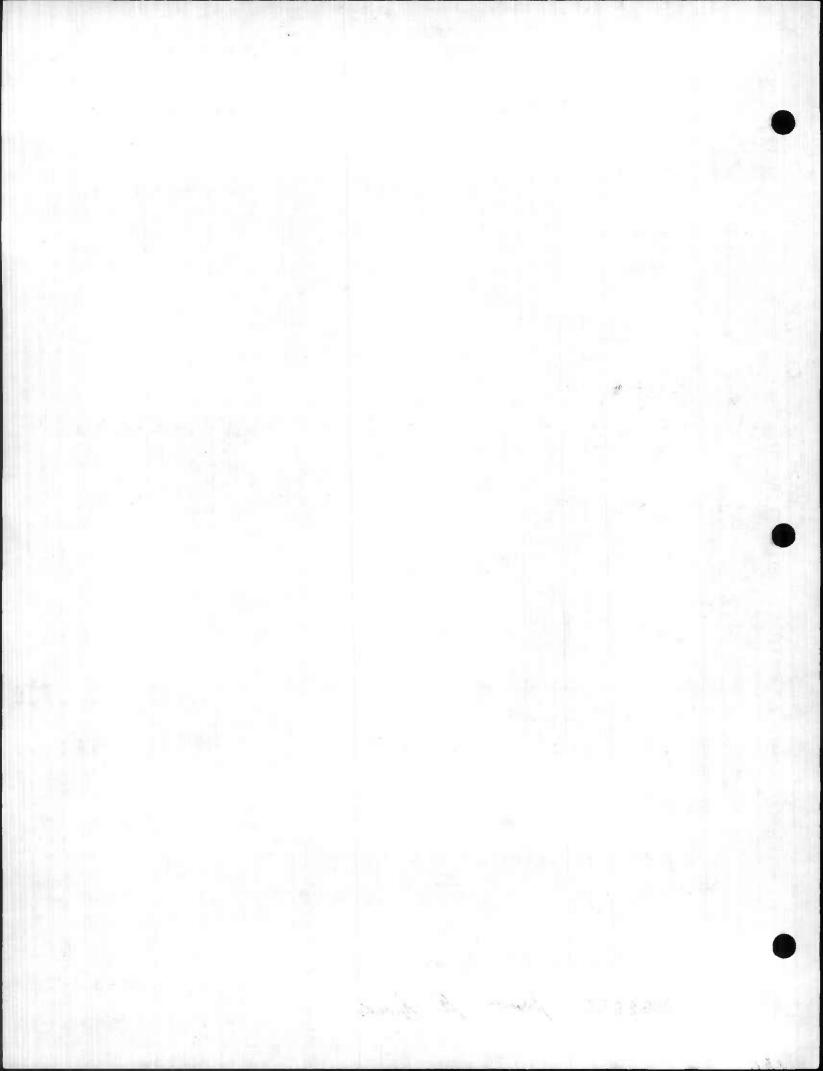
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29b. Signeture and title of certified 29c. License number 29d. Data signed (Month, Dey, Year)

ne and eddress of person who completed ceuse of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD herie 31. Date filed (Month, AUG 2 6 32. Registrer's Signature

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26936 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 3:25 PM Ellen Elizabeth Bauer August 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Joseph Ritchie House Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. May 8, 5. Sociei Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 1□M 2K)F Months Yrs. 87 220-05-5113 Maryland Usuel Residence of Decedent 10a. State West 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Berkley Martinsburg Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25401 2017 N. Ridge Drive United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Ziesel Grace Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Menacker (Daughter) 2017 N. Ridge Drive Martinsburg, WV 25401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 8-27-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 21. Signature of Fyneral Service Licens 22. Name and Address of Facility 1. Settle Mitchell-Wiedefeld Funeral Home, Inc. Leven 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 Yss 2 No 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28e. Date of injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

AUG 27 1999

29b. Signature and title of certific

30. Name and eddress of person who completed cause of death (Item 29a) (Type, Print) 32. Registrar's Signature

828 N. Gutanst, Va 100 And 21201

29d. Date signed (Month, Day, Year)

8-26-99.

DHMH 16 Rsv 6/95

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Mindrel Examinat must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Heelth end Mental Hygiene. Introportant: If item 27 is marked other than "r. any injury or other traumatic event, the Med ence.

Physician

/Medical Examiner

ician and bunal-transit

attending physician for use as the buria

ata has been signed by the page 2 should be detached

certificata has

death.

after death Director:

To the Hospital within 24 hours a To the Funeral C completely filled

Box 68760.

Examiner

Physician/Medical

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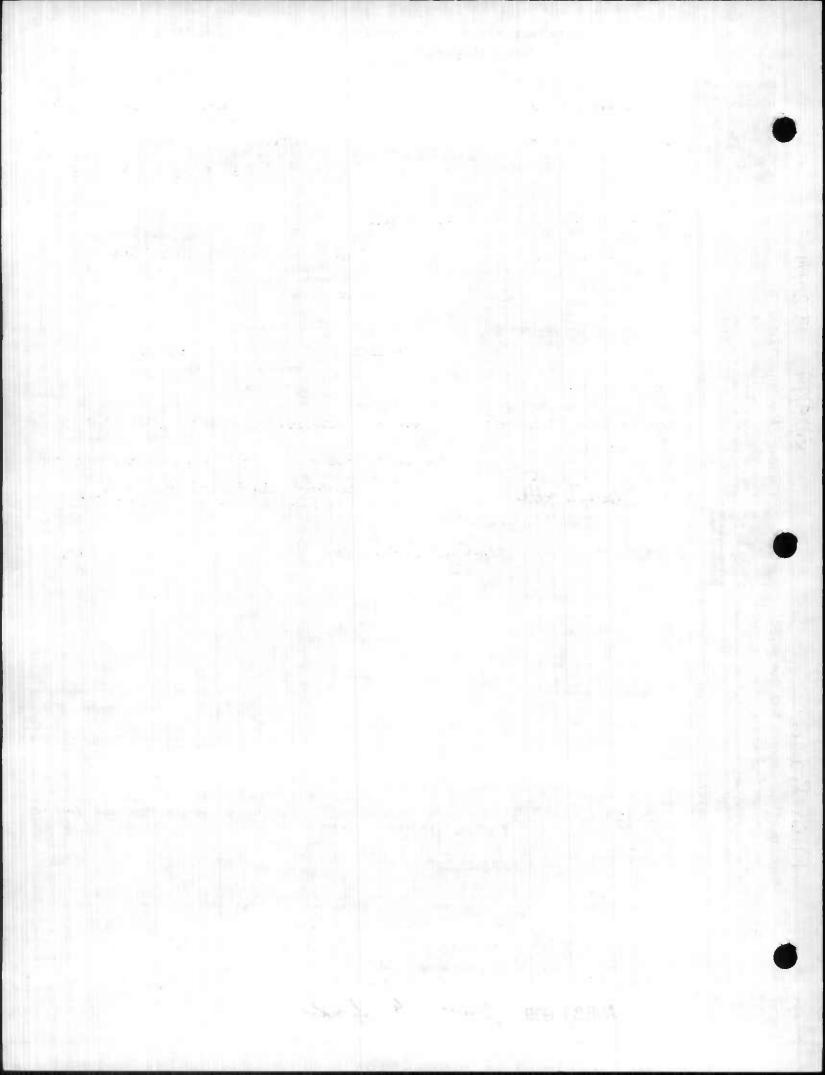
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Certification:

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

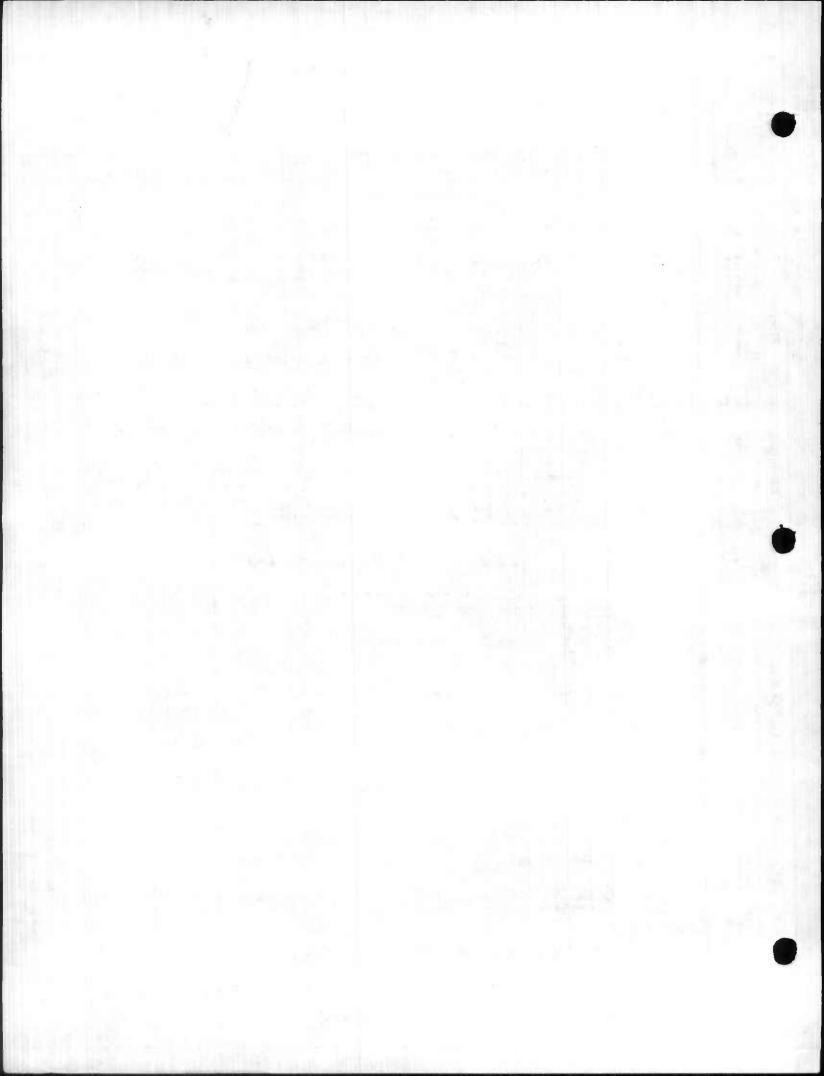
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** ANTHONY AUGUST 06154 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE 5: NAF /4. HOSPITAL BAUTIMORE 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months JAM 20F Days Hours Min 219-28-0513 Yrs. Director Usual Residence of Decedent the Maryland 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Director ACTIMORE (ITY 10f. Zip Code 10e. Streat and Number 10g. Citizen of What Country? 6 RHELEY AVE USA Nerns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene, important: if from 27 is marked other than "natural", or hen any injury or other traumatic event, the Medical Page 2010. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No by Specify: 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SHIPPING MERCHANT MARINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be DELBARRONI 19a. Informant's Name/Reletionship (Type, DONA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DESIREE Brito. My 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20e. Method of Disposition 20c. Location - City or Town, State 8 26 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Metro CREMATORY Brita Ma 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DELLA NOCE +SONS FUNERAL HOME 322 S. LIGH ST. BUTA, 231 Part D Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) For I winent Hepotes. Fai. 14 rc. Examiner Due to (or as a consequence of Examine Meta-Civer deserse physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 fes 2 No 3 Probably 4 Unknown Records, þ 24a. Was en eutopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death? Completed 1 ☐ Yes 2 ☐ No 1 Yes 28 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical axeminer? Certification: To Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1-2Neturel 5 Panding investigation deeth. 1 Yes 2 No 2 Accident within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely lilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 25 RE5000 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) West Boundary Balinners, MD 21215 2401 David 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 2 7 1999



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death BARLOW **Physician** JAMES 24, 1999 10:25 PM AUGUST /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Church Home Hospital Baltimore City N/A 5. Social Sacurity Number 6. Sex 1 M 2 □ F If Undar 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funerai** Days 413 16 1344 83 Yrs. FEBRUARY 16,1916 Director Georgia Usuel Rasidanca of Decadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified. Maryland Baltimore Dundalk 1 Yas ZXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8002 Wallace Road 21222 United States 12. Wes Dacadant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No tf Yas, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status 1 Naver Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify P 3 Widowed 4 Divorcad White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education
(Specify only highest grade completed) 16h. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 7 Years Mechanic Automobile Repair 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be Daniel W. Barlow Fanny Giddens 19a. Informant's Name/Ralationship (Type, Print) Wife 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) 8002 Wallace Road Dundalk, Maryland 21222 Mrs. Annie Louise Barlow 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatery, cramatory or other placa) 20c. Location - City or Town, Stata MAN Burial 2 Cramation 3 Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Mem. Gdns. 8/27/99 Middle River, MD 21. Signature of Funeral Sarvice Licensaa mpor my in 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai HYPOXIC ENCEPHALOPATHY Immediata Causa (Final disaasa or condition rasulting in death) Examiner ASPIRATION buriel-transit Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last and Box 68760, physician Physician/Medical the Due to (or es e consaquanca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 8 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical axaminar? Be 28. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28c. Injury et Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: After 5 Pending Invastigation 1 Natural or Attending effector: Aft 1 Tes 2 No 2 Accidant 3 Suicida 6 Could not ba 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 ☐ Homicida To the Hospital or within 24 hours eft To the Funeral Discompletely filled in 12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifiar D 17695 29b. Signature end titla of cartifiar
Adallah 29d. Date signed (Month, Day, Year) J. Helou M.D. AUGUST 24, 1999 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) CHURCH HOSPITAL, 100 N. BROADWAY, BALTIMORE, MD 21231 ABDALLAH J. HELOU, M.D. 31. Data filad (Month, Day, Year) 32. Registrar's Signature State AUG 27 Registrar

THE STATE WHEN THE RESIDENCE No. 2 September 1981 The state of Manager Configuration and the Configuration of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24, 1999 **Physician** AUGUST 9:55 PM ROBERT ALLEN) BOENNING /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. lest birthdey) If Under 1 Year | II Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Dey, Year) Birthpiece (Stete or Foreign Country) **Funeral** 1 2 F Days Yrs. 218-28-9747 Director NOV. 10, 1931 MD. Usuai Residence ol Decedent the Maryland 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD. BALTIMORE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2116 FOREST PIDGE PD 21093 .S.A 14. Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Ø ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status should be filed within 72 hours efter and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grede com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Etementary/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE 12 ENGINEER 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) . Peges 1 end 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth lury or other traumatic even CARL JOSEPH BOENNING HELEN MAY RABER 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JANET HARRY , FALLS RD. HAMPSTEAD NIECE 18710 MD. 21074 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State Date AUG. 25, 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State permit. Peg Department Important: If any injury o 4 ☐ Donetion 5 ☐ Other (Specify) DULANE VALLET MEM. GONS. 1999 THONIUM, MD 21. Signeture of Eugeral Sentica Licensee 22. Name and Address of Facility EVANS FUNCEAL CHAPEL MD. 2325 YORK RD. 21093 MULINOMIT 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** CARDIOPULMONARY ARREST /Medical HOURS immediate Cause (Finat disease or condition resulting in deeth) Examirier Due to (or es e consequence of): CORONARY ARTERY DISEASE YEARS and Il-trensit be executed Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physiclen at sthe burial-t MITRAL VALVE REGURGITATION Box 68760 YEARS Physician/Medical Due to (or es a consequenca ol): 98 ettending ADRTIC VALVE REGURGITATION YEARS ed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed has 2 No 1 Yes 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitai: 1

tnpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Neturai 5 Pending To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Afte completely filled in by the fun 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated. 29b. Signature and might 29c. License number 29d. Date signed (Month, Dey, Year) D0053607 26,1999 MO

State Registrar

31. Date filed (Month, Day, Year) AUG 27 1999

PAUL G. BURNS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth Month Eleanor Mae Racon 1999 12:55 P.M August 4b. City. Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery 7. Aga (In yrs. last birthday). If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M XXF March 18, 1920 Shelburn, IN 309 20 0478 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 1 Yes 3€No Terra Haute Vigo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 47802 1218 S. 4th Street United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yas 2 ☑ No If Yes, Give 1 ☐ Nevar Marriad 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Child Care Elementery/Secondary (0-12) College (1-4or 5+) Provider Self Employed 18. Mother's Nama (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Charles Baldwin Underhill Flora Mabel McCammon 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charles Bacon 13103 A. Shadyside Lane Germantown MD 20874 20e. Method of Disposition

X Buriel 2 Cremetion 3 Removel from State Sept. 3, Deta 1999 20c. Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Arlington National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Arlington Virginia 22. Nema and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finei disease or condition resulting in deeth) Neumonic Due to (or es a consequence of): Sepsis

Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasuiting in deeth) Lest , astric Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertensu 24b. Were sutopsy findings avelleble prior to 24e. Was en eutopsy performad? completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 hpatient 2 ER/Outpatient 3 DOA 27. Menne of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding investigation 1 Yes 2 No 2 Accident

the death certificate be executed P.O. Box 68760. Physician:

ettending physician and for use as the burial-trans Division of Vital Records. certificate has t lirector, page 2 s After this or Attending r death. the in by Dire 24 hours

Physician

/Medical

Examiner

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Completed

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

7 is marked other traumatic event, t

permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked oths any linjury or other traumatic event page.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

To

Certification:

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with the Maryland

filed within 72 hours after death thygiene.

Baltimore, Maryland 21215-0020

29e. Certifier (Check only one) 29b. Signeture end title of certifie

B0664

3 ☐ Suicide

4 Homicide

Doc tor

29c. License number

tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29d. Data signed (Month, Dey, Year)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

Ave 7640 carroll

Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

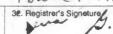
akoma Park MD

State Registrar

31. Dete filed (Month, Dey, Year) AUG 2 7 1999

6 Could not be

David



within 2 To the

Examiner The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. or Attending Physician: death. s after death

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

Director

288-1

Name 23a or

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Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Part It. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed Be 25. Was case referred to medical axaminer? 1 Yes 2 No edical Certification: To 27. Manner of Death 1 Natural 2 Accident 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date fited (Month, Day, Year)

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Name and address of person was completed cause of death (Item 23a) (Type, Print) 4920 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August Ellwood Н. Cross 1999 808 A /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltmore to SpitA MAI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Yrs. Director Aug 26, 1920 Maryland 215-09-0467 Usuel Rasidence of Decedent 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits d.2 should be filed wittin 72 hours after death with the Marylai his and Mental Hygiens. The hours of the season 23a or 23a-f show the transfer overst, the Medical Examiner must be notified at transfer overst. The Medical Examiner must be notified at 1 ☐ Yes XX No Directo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Brightfield Road 21093 Funeral USA 12. Was Dacedent Ever in U,S. Armed Forces?

12. Wes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify. þ Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Wreckmaster Railroad permit. Pages 1 and 2 abouid be file Department of Health and Mental Hy Important: If Nem 27 is marked othe Any Injury or other treumetic event 17. Father's Name (First, Middle, Last) 18. Molhar's Nama (First, Middle, Maiden Sumama) William Н. Cross Lvda Brooks 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Judy Spencer Daughter 5018 Catalpha Road Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 D Burial 2 Cremation 3 Removal from State Lake View Memorial 8/26/1999 Eldersburg, Maryland 4 Donation S Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approxima Approximate interval Between Onset end Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examine Covonos. physician and the bunal-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medicai Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings aveilable prior to completion of cause of daeth? 24a. Was an autopsy performed? Completed A(2 hione certificate has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ■ R/Outpatient 3 ☐ DOA 70 Hospital or Attending Phys
 24 hours after death.
 Funeral Director: After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 1 Note that the best of my knowledga, daath occurred at the time, date and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) To the Within 2 29b. Signature end title of certifier 29c. License number 29d. Dale signed (Month, Dey, Year)

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 \mathcal{S} 31. Date filed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

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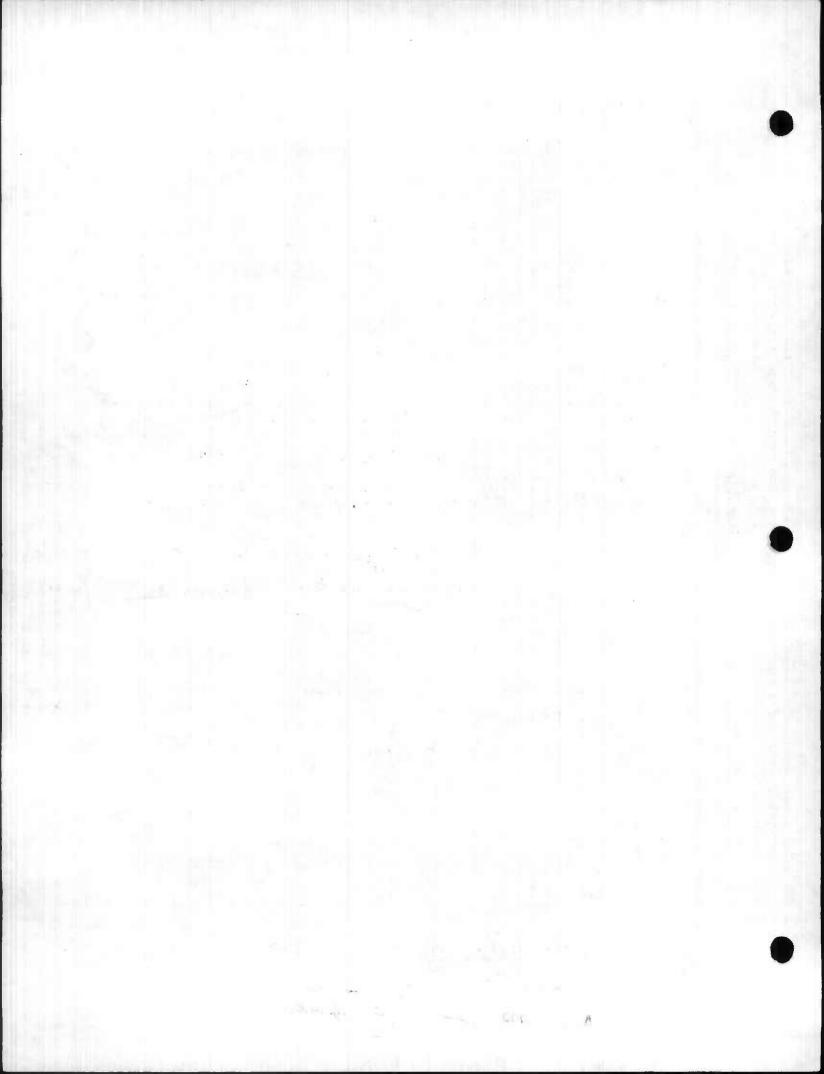
32. Registrar's Signature

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GLENN A. CONNER State of Maryland / Department of Health and Mental Hygiene Q AMEND: #23 PART I, 27, 28A-F PER MEO G775 9-1-99 WGertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0941 AM GLENN CONNER A. 23, 1999 AUGUST /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8053 DELHAVEN ROAD DUNDALK BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1⊠M 2□F 42 Yrs. Director 213-68-9803 2,1957 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yas 2 No Director 28e-f 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? mant be United States 21222 8053 Del Haven Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, White, etc. Pages 1 and 2 abould be filed within 72 hours after nent of Health and Mental Hyglene.

ant if Rem 27 is marked other than "natural", or its ury or other traumatic event, the Medical Examines. 1 ☑ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Dry Wall Mechanic 12 Years 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Clara Louise Cooper Ernest Glenn Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Rabon Ave. Dundalk, Maryland Louis D. Conner/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or 8/26/1999 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Lycks pronous 7922 Wise Ave. Dundalk, Maryland 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one ceusa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final COCAINE AND NARCOTIC INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bud Due to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequence of) 98 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 □ Probably ♣Q\Unknown 1 Tyss 2 No Division of Vital Records, þ 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? page 2 : has 2 🗆 No XXYes 2 No certificata XXYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner / 1.XXYes 2 □ No Other: 4 Nursing Home **XResidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) FOUND: AUG 23, 1999 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Α 1 Natural 5 Pending investigation FOUND: 1 Yes 2 No UNKNOWN 24 hours after death.

Funeral Director: A 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 Accident 6) Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 8053 DEL HAVEN ROAD, DUNDALK, MD. RESIDENCE Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner es stated.

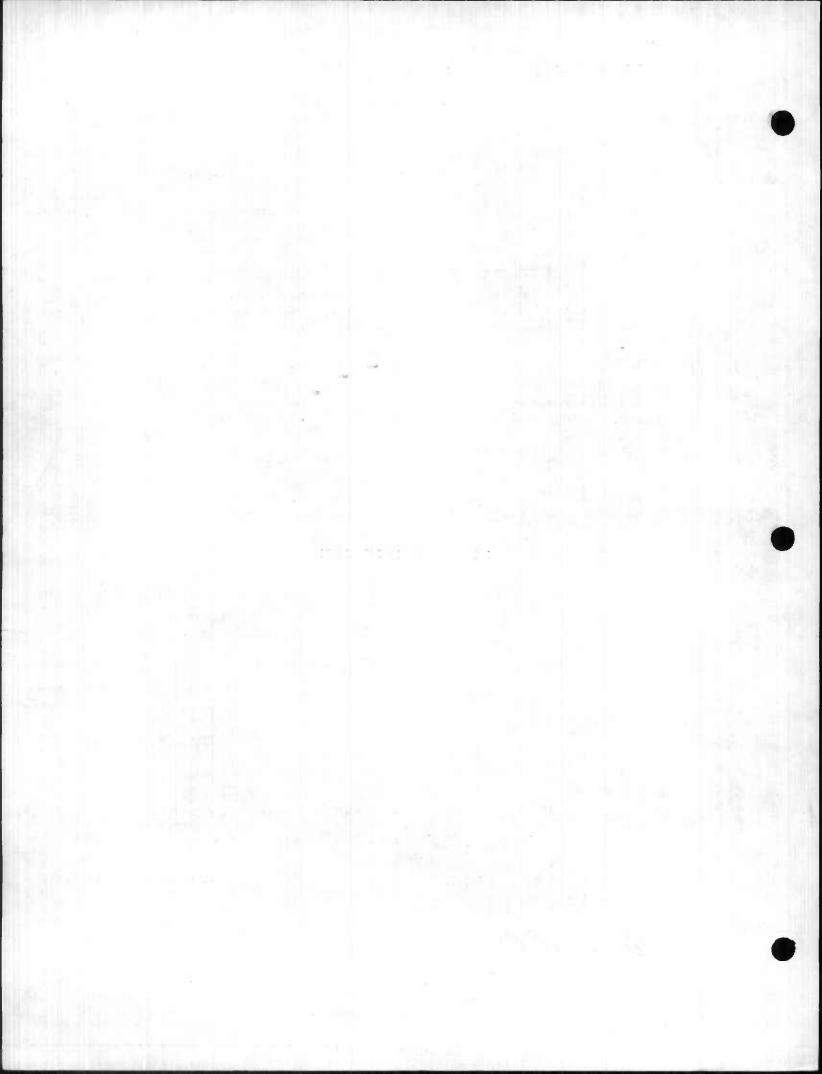
Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2 5 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number O.C.M.E. AUGUST 24, 1999 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Theodore King M.D. 31. Date filed (Month, Day, Year) 32. Registers Signature State

State Registrar

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32. Registers Signature B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death over August 25 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Mirchest DYSTEINS BALTIMORE N/A ff Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **₩** M 2□ F Days 401-58-4816 57 DEC. 17, 1941 ILLINOIS **Uaual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 405 HOWARD MANOR DRIVE U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☑ Married 1 Ø Yes 2 □ No 1960 -1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 OWNER CLEANING FRANCHISE 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GLEN COVERT MARY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addreas (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. JANET COVERT (WIFE) 405 HOWARD MANOR DRIVE, GLEN BURNIE, MD. 21060 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GORDON CEMETERY 8/31/99 DANVILLE, ILLINOIS 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 plications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, one cause on each line. Intarval Batweer Onset and Death Immediate Cause (Finat disease or condition resulting in death) CRAMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work?

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Examiner Physician/Medical þ Completed Certification: To Be filled in by within 24 hours a To the Funeral C completely filled

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Physician

/Medical

Examiner

filed within 72 hours after

altimore, Maryland 21215-0020

25. Was case refarred to medical examiner? 1 Yes 2 No

> Natural 2 Accident

3 ☐ Suicide 4 Homicide

29a, Certifie (Check only one) 5 Pending investigation

6 Could not be detarmined

Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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Shah 31. Data filed (Month, Day, Year)

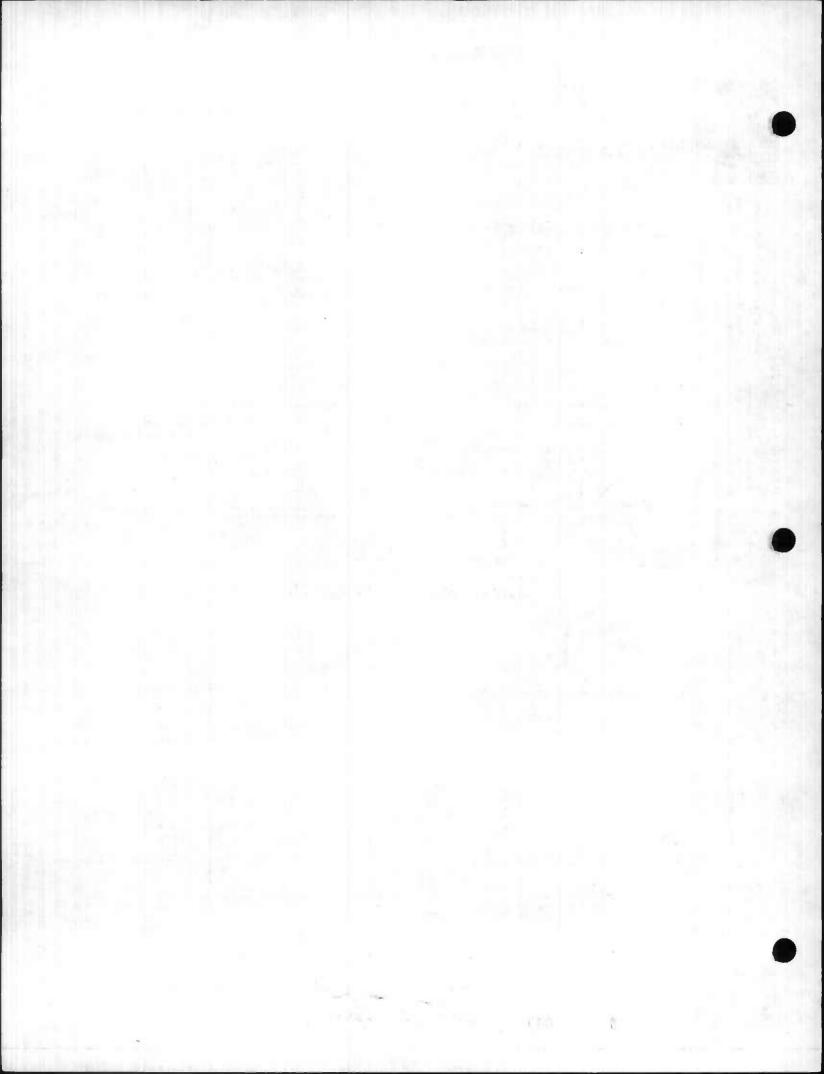
32. Registrar's Signature

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State Registrar

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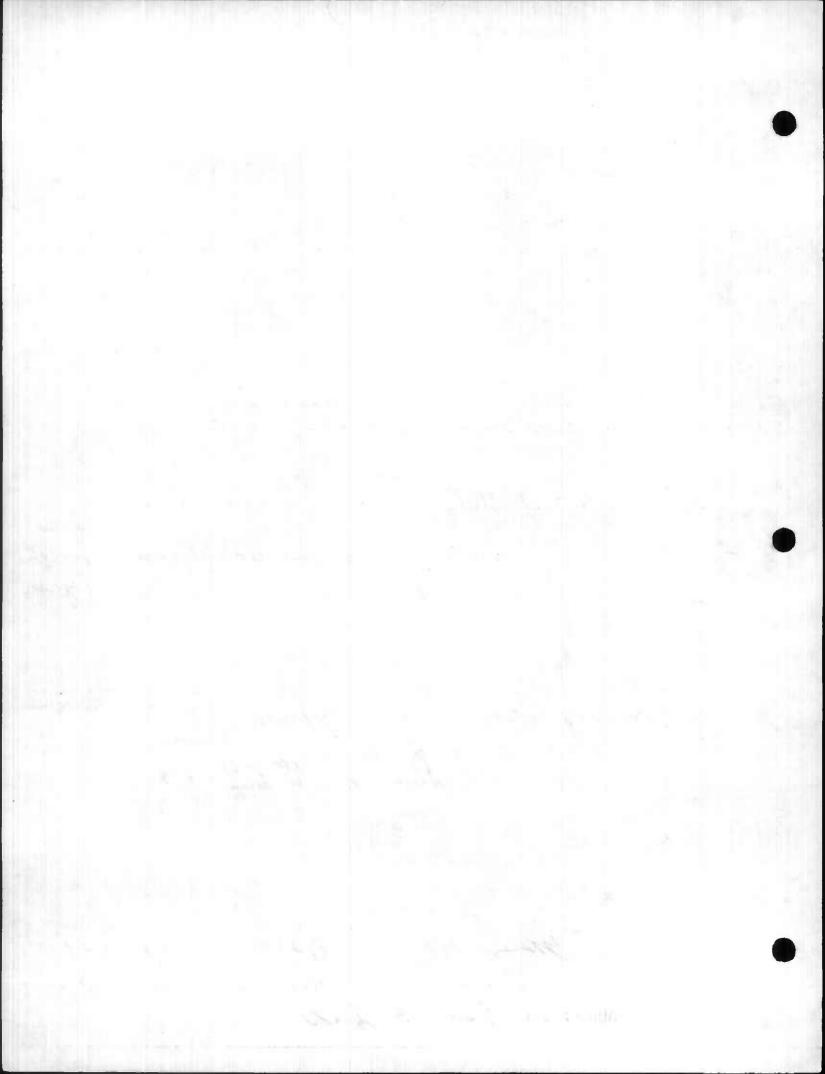


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State of Maryland / Department of Health and Mental Hygiene 26945 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death **Physician** A. Marie August 27 1999 5:40 am /Medical 4e Fscility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Knollwood Manor Millersville Anne Arundel | Hunder 1 Year | Hunder 24 Hrs. 8. Dete of Birth Months Days Hours | Min. | April 4,1912 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 3 F 87 219-16-6238 Director Maryland Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director 28a-1 Anne Arundel Millersville 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? must be o 21108 503 Windy Knolls Court USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 8 Specify: White py 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme /First, Middle, Meiden Sumemei Pages 1 and 2 should be nent of Health and Mental George Sebold Lavina A. McGettigan 19a. Informant's Neme/Relationship (Type, Print)
(Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 l Winnie H. Humberson 503 Windy Knolls Court, Millersville, MD 21108 in-law) Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete = 5 Department Important: It National Memorial Park 08/29 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Ligana 22. Name end Address of Fecility Hardesty Funeral Home, P.A. nella 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical dehydration malnutvition Examiner Physician/Medical Examiner repetit. nding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Box 68760. that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Be Completed 1 Yes 2 No 1 TYes 2 No possille of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division After 5 Pending 1 Natural after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29d. Dete signed (Month. Dav. Year) 29c. License number 29b. Signeture and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSIL Crain 31 Dete filed (Month, Day, Year) 32. Registrer's Signature State AUG 27 1999 Registrar

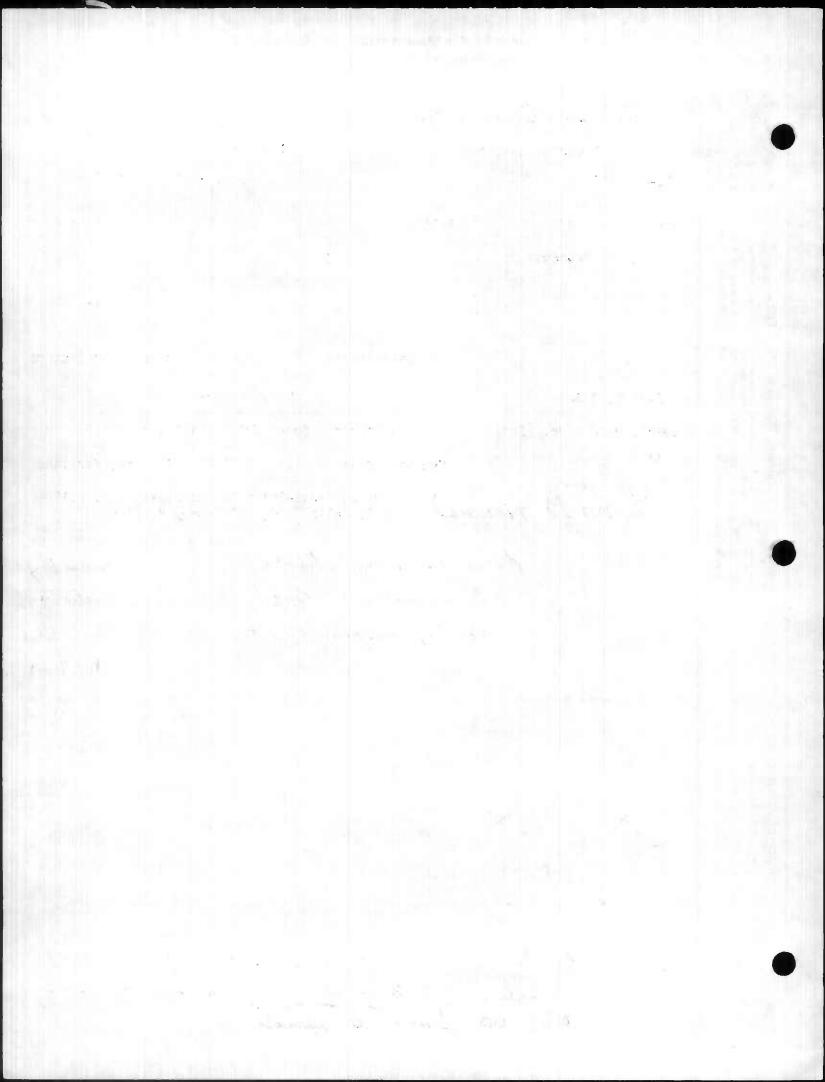
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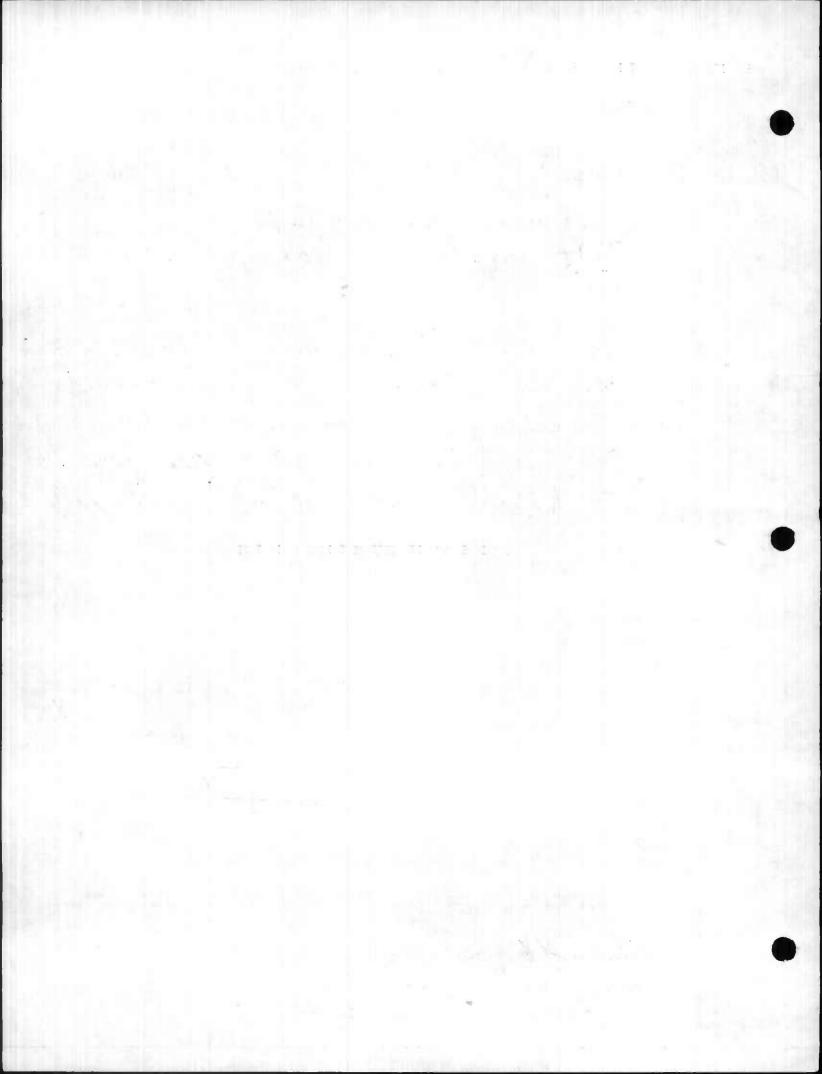
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State of Maryland / Department of Health and Mental Hygiene O O

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AMEND I	TEMS	: #23 PART I, 27 PER ME	0 G775 9-8-99 WR.		e of Death		g. No.	20	941	
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/Med		Lenny I	Juane 1	Doan		AUGUST	1115	999	1809 PM	
Exam	iner	4e Fecility Neme (If not institution, give	e street and number)		4b. City, Town, or L	ocation of Death	4c. County	of Death		
		CARROLL COUNTY G			WESTMINS			RROLL		
Funera Directo		5. Social Security Number 6. S 183448055 1 Usuel Residence of Decedent	9X 7. Age (In yrs. 3	7 Yrs. If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Dete of Birth (Month, Day,	Year) -61	Country	on Find	
Pue tend		10a. State 10b. County	10c. City	, Town or Location				10d.	. Inside City Limits	
the Mary	5-0020 72 hours after death with the Maryland natural, or items 23s or 28s-f show or at Examinar must be notified at seted by Funeral Director	PA Ad	lams of	lami /to	n Tup.		- Citi414	Pro-1 Country	1 ☐ Yes 2 S No	
23e or		10e. Street and Number 9 Deffe	vson Dr	10f. Zip	17301		g. Citizen of W	4		
15-0020 72 hours after dearnatural, or frame	by Fune	11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever In U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	S. 13. Was Decedif Yes, spec	lent of HispanIc Órigin? (Spirify Cuben, Mexican, Puerto ≥ In Specify:	pecify Yes or No- o Rican, etc.)		- American k, White, etc		
5-0 72 ho		15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usua	al Occupation rk done during most of work	kina 1	6b. Kind of Bu	siness/Indus	stry	
within within then	Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	Sale	se retired) 4 MGV.		Lawe	£6	anden	
	Be C	17. Father's Name (First, Middle, Last)	0 1	700.	18. Mother's Nem	ne (First, Middle, M.	aiden Sumam	9) /	11	
W 0550	ToE	Glen	Ray Di	san	Mar	y An	retta	Wil	dermai	
Maryla d 2 should th and Mer T ie merke treumetic		19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address	(Street end Number or Ru	al Route Number,	City or Town.	State, Zip Co	ode)	
C = N +		Laura Jane	Doan	9 Jet	terson.	Dr Al	botts	Yown	101730	
0 % 5 2 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from Stete	lece of Disposition (Nan emetery, crematory or o	ther place)	Date 2	Oc. Location -	City or Town	1 Male	
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Balt Permit. Depart Importu		21. Signature of Funeral Service Licen	Multer	11 lets	d Address of Facility 5	49 Car	115/2	PAIN	331	
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of Vita Physician: rthis certific eral director,	ToB	examiner? ▼QXYes 2□ No	Hospitel:	ER/Outpatient X3000	Others	ome 5 Residen		or (Specify)		
Division of Vital Records, To the Hospital or Attanding Physician: The law requires the within 24 hours after death. To the Funeral Director; After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be		27. Menner of Death 1 1 Netural 5 Panding 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28d. Describe how	28d. Describe how injury occurred					
Division or Attanding after death. Director: After I in by the fune	Certification:	3 Sulcide 6 Could not be determined	r, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			Route Number,			
ours a filled	3	29e. Certifier 1□ Certifying Phy	ysician: To the best of my know	viedoe, deeth occurred	at the time, dete and plece	end due to the car	use(s) and ma	nner as state	ed.	
To the Hospital within 24 hours a To the Funeral completely filled	edical		iner: On the basis of examinet and menner steted.							
To the To the Company	Σ	29b. Signeture end title of certifier	111	290	. License number	29	d. Dete signed			
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		30. Name and address of person who o	1.0	23a) (Type, Print)			51.00	100		
	ate	31. Dete filed (Month, Dey, Year)	32. Registrer's Stone	ture	t, Baltimore	, Marylan	d 21.20	1		
Regis	ate trar		1999 Dener	1. A.	park					

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) Date of Death ROBERT GARRETT EMORY, SR. 4b. City, Town, or Location of C 4a Facility Nama (If not institution, giva street and number) 4c. County of Death LEVINDALE NURSING CENTER BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) SEPT 7, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Months Days Hours MARYLAND 220 22 3327 71 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 WALBROOK AVENUE 21216 U.S. OF A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry MANUFACTURER OF College (1-4or 5+) UNKNOWN ementary/Secondary (0-12) STEEL PISTON RINGS UNKNOWN STEEL WORKER 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES EMORY GEORGIA ANN BARRON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5306 HADDON AVENUE ROBERT G. EMORY, JR. (SON) BALTIMORE, MD. 21207 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata MT. ZION CEMETERY 9/1/99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service License WIS T. GWYNN 22 Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 Twinn 4517 PARK HEIGHTS AVENUE BALTO., MD. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disease or condition rasulting in death) along Friles Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Lest Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 2)X No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Yas 1 Mnpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

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Examine

Physician/Medical þ Completed å

Certification: after A 24 hours Direction of Funeral Direction edical

27. Manner of Oeath

1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

State Registrar

5 Pending

6 ☐ Could not be

28a. Data of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Yas 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month. Day, Year,

ripleted cause of death (Item 23a) (Type, Print)

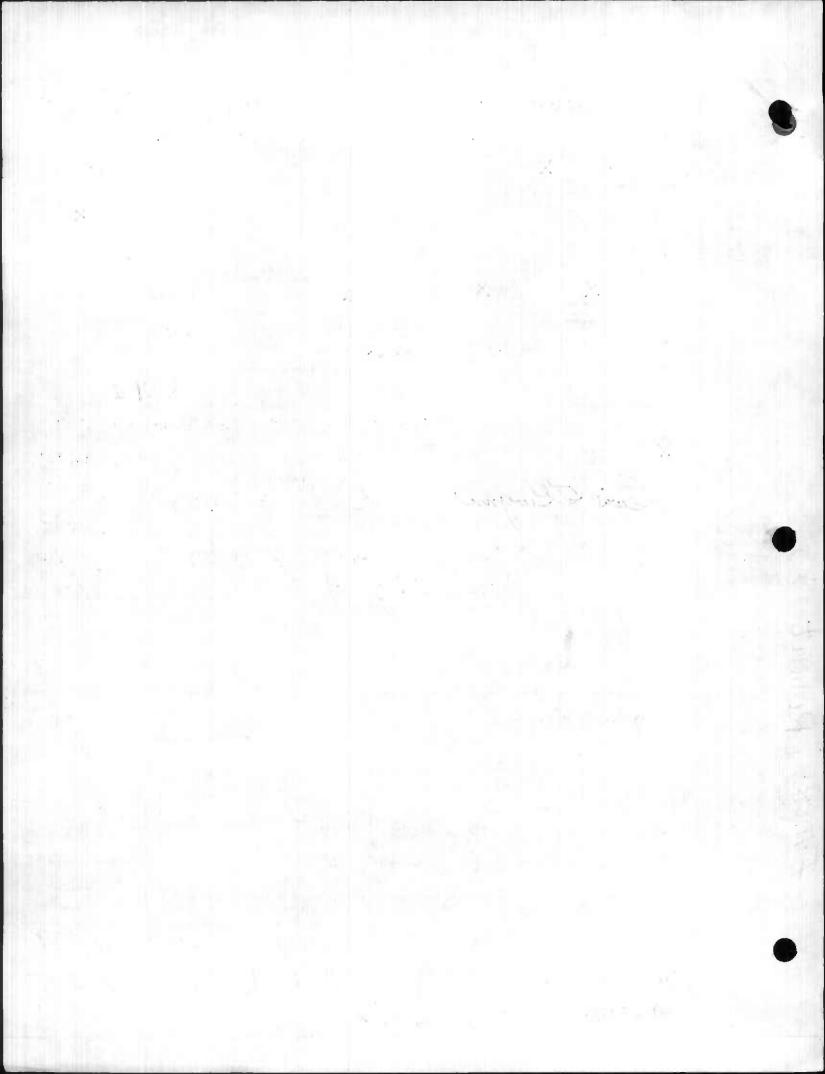
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Dascribe how injury occurred

Vithin 2 To the

28b. Tima of

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Account William **Physician** H. Ellison 0827 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Baltimor if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplece (State or Foreign Country) 1 M 2 □ F Deys 70 Yrs. Months Hours Difector JUNE 8 1929 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE ROSEDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1415 SPRING AVENUE Funerai 21237 USA 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married "natural", or 1 ☐ Yes ŽXNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retirad) Elementary/Secondary (0-12) College (1-4or 5+) 10 LONGSHOREMAN SHIPPING 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) Be 0 AARON ELLISON MARGARET unk. 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health If Itam 27 MARY C. ELLISON / WIFE 1415 SPRING AVENUE ROSEDALE, MD 21237 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, State to 1 Burial 2 □ Cremetion 3 □ Removel from State OAK LAWN CEMETERY 8/26/99 BALTIMORE, MD 4 Donetion 5 Dother (Specify) 21. Signeture of Funeral Service Licen 22. Name end Address of Fecility CVACH/ROSEDALE FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

April 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

April 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

April 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** l'neu monia Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner Gram negative Sepsis sician and bunal-transit The law requires that the death certificete be executed Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In deeth) Lest Box 68760. physician s the buna Due to (or es e consequence of) USB BS P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? tailing 1 Yes 2 No 3 Probably 4 Honknown End Stage renul by Records, sign Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? metabolic acidosis page 2 certificate 1 Yes 2 → No 1 ☐ Yes 2 ☐ No Vital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Thripatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Lo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ō this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Division 5 Pending investigation 1 Neturel To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 3 ☐ Sulcide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 10 certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

8125 199

DO043662

State Registrar

NAME KNOWN TO PHYSICIAN

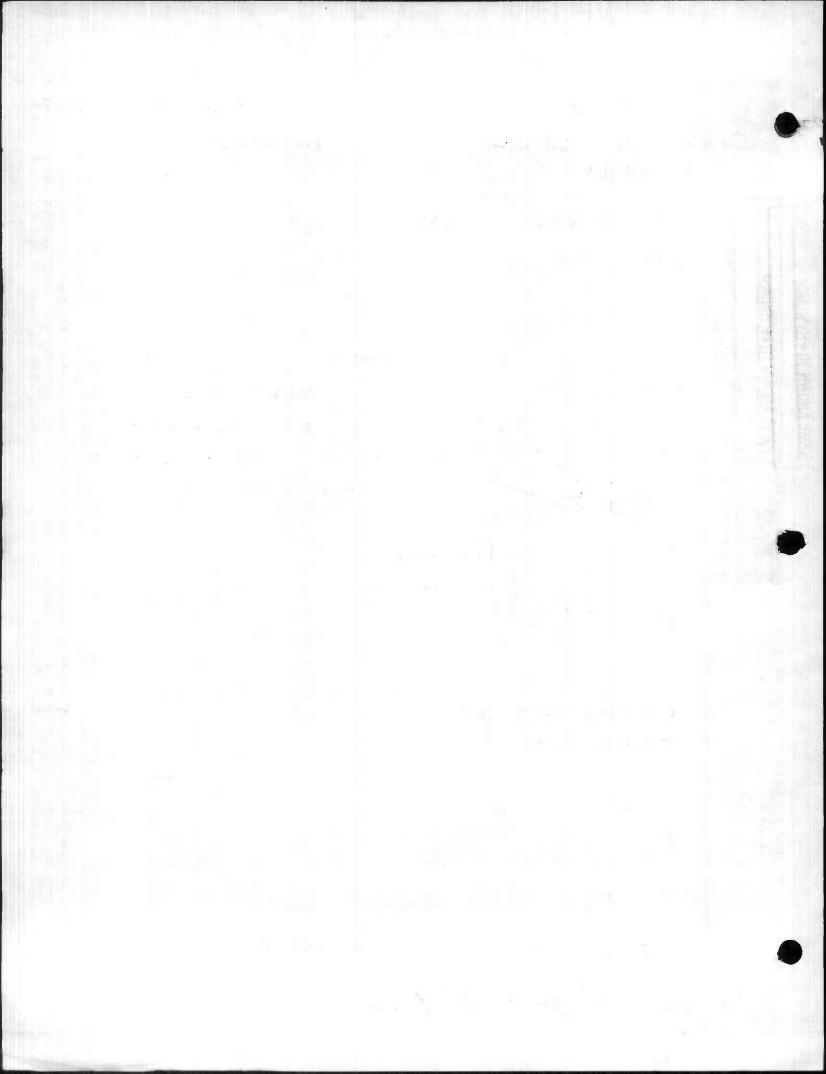
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

WILLAM J. BUYCE

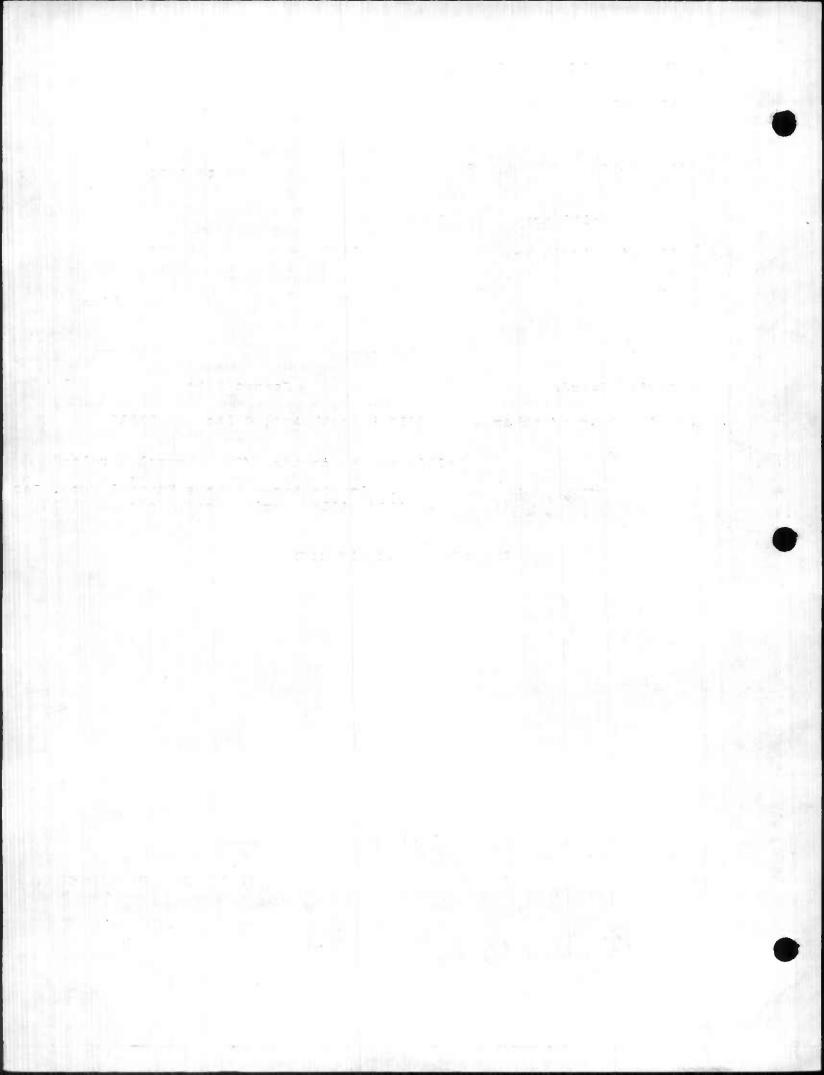
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32 Registrer Signeture



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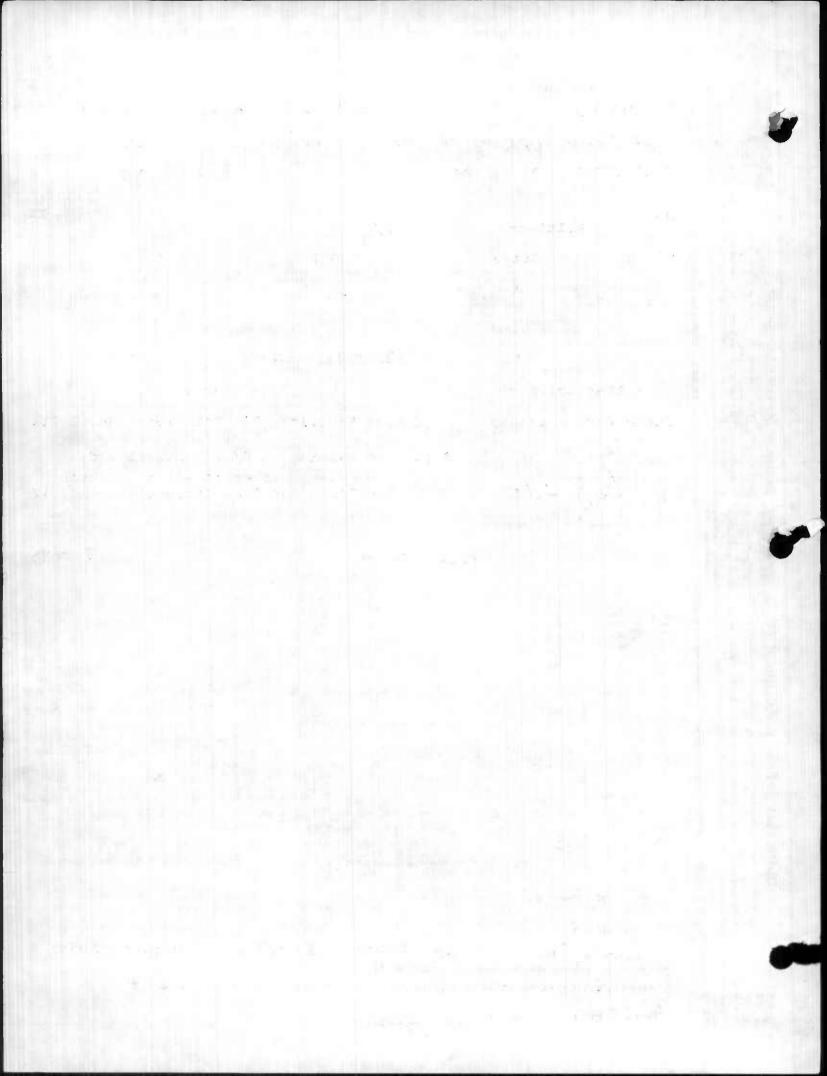
ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 12:24 PM THOMAS 1999 20 AUGUST /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Boltmore, City HOPKINS HOSPITA If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** Months Days Hours 1 XM 2 F 218.10.7602 Yrs. 84 Director July 28,1915 Usual Residence of Decedent with the Meryland r 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 Yes 2 No Director Baltimore N / A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examples must be a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or frems 23s any injury or other traumatic event, the Man 604 Hillstead Drive 21022 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes X☐ No Specify: Specify: White by 3 ☐ Widowed 4 🛱 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) Coilege (1-4or 5+) Furniture Business Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Goldstein Rose Mintzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Levin / Daughter 4 East Highfield Rd. Baltimore, Md. 21218 20b. Piaca of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Rerpoval from State Baltimore Washington 8/21 Laurel, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Fecility Sterling-Ashton-Schwab 21. Signature of Fulleral Service License Olers 736 Edmondson Ave. Catonsville, Md.21228 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final 7 DAYS PNEUMONIA disease or condition resulting in death) **Examiner** Examiner that the death certificate be executed end Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician er s the buriel-to Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 98 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 № Unknown 1 Tyes 2 No by The law requires 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen page 2 s 1 Yes 2 No 1 □ Yes 2 □ No certificate or Attending Physician: director 25. Wes case referred to medical exeminer? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: After t 5 Pending 1 Natural 1 Yes 2 No investigation hours after deeth. I Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 冠 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as slated. edical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 0 August 20, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Bilchick, 600 N. Wolfe Street Baltimore, MD 31. Date filed (Month, Day, Year) AUG 2 7 1999 32. Registrar's Signature State

Registrar

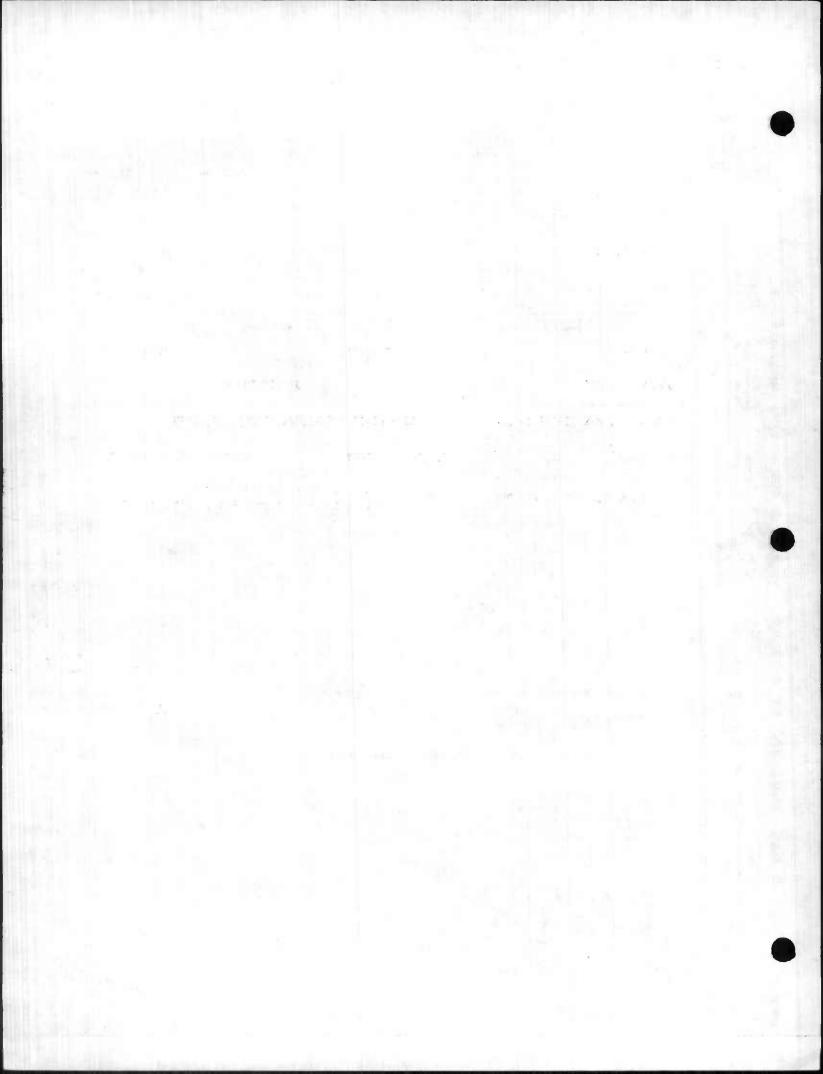


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #1 PER MD G774 8-31-99 WR. Certificate of Death Reg. No. 2. Data of Death 1. Deced**é**nt's Nam*e (First, Middle, Last)* ANGELENA EADDY Month **Physician** /Medical n of Death 4a Facility Name, (If not institution, give street and number) 4b. City, Town, or Locatio 4c. County of Examiner Sal 6 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 214-54-2834 Months Hours 1□ M 200 F 50 Yrs Director 04/14/49 Alabama Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits ehow. must be notified at MD N/A Baltimore 1 ¥ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Key Avenue 21225 USA Neme 23a Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Bace - Amarican Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours effer 1 Never Married 2 Married 21215-0020 Specify: BLACK natural, or 1 ☐ Yes 2 ☒ No Specify: 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi ment of Heelth and Mental Hygien lant: If item 27 is marked other th lury or other traumatic avant, the 12th Grade DOMESTIC HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Nama (First, Middle, Maiden Sumame) 8 JAMES MCLEMORE JANNIE THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLENE McCOMBS/SISTER IN LAW 1243 LIMIT AVENUE, BALTIMORE, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Department of Important: If any Injury or poles. MT. ZION CEMETERY 8/19/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE VAUGHN C. GREENE, PER DVR 5151 Baltimore National Pike, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner ensiler physician and the burief-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Box 68760. Physician/Medical the the Due to (or as a consi quence of) for use es ed by the e Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 2 No 1 Yas 3 Probably 4 Unknown signed b py 24b. Wara autopsy findings available prior to complation of cause of death? been si 24a. Was an autopsy performed? Completed 200 No cartificata Division of Vital Attending Physician: director. Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3D DOA Certification: To 1 funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours effect death.
To the Funeral Director: Afte completely filled in by the fun 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and manner as stated.

Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and medical examiner stated. 29a. Certifie edical mail 29b. Signature and title of certifier. 29c. Licensa number 29d. Date signed (Month, Oby, Year) 30. Name, and address of person who completed cause of death (Item 23a), (Type, Print) DOUGLA MICK 21225 31. Data filed (Month, Day, Year) 32. Registrar'a Signatura State AUG 2 1999 Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedant's Name (First, Middle, Last) **Physician** REIG · /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number **Examiner** SILVER SPEING 1405DITAL MONTGOMERY If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Month, Day, 7. Age (In yrs. last birthday) Security Number 100M 2□ F Months -22-914 Yrs. Director Usual Rasidenca ot Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examiner must be notified at Washington 1 PYes 2 No DC Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3 DIIOL DT. 5.A Funeral permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Yeer or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Biack, Whita, atc. 1 Navar Merried 2 Marriad 1 Yas 2 No Maryland 21215-0020 Specify: þ MHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) PROFESSIONAL > 17. Father's Neme (First, Middle, Last 18. Mothar's Nama (First, Middla, Maiden Surnama) NOWN JZEIG 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 20b. Place of Disposition (Nama of cematary, crematory or other place) N. Capital ST NES WASh DC 20317 MATIHEW A. HINTON other Saltimore, 20c Location - City or Town, Stata 20a. Mathod ot Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata any injury or SAPERKE CREMATORY 13099 Della Ville. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LATNING'S FUNCTION 385/ GOOGGA JIS, NO. WAShingTo DE 2001/ SURVICE 21. Signatura di Funeral Sarvica Licensee CC0348 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in daath) Examiner Examiner bunal-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated avants resulting in deeth) Lest Bud racerebral physician Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or es a consaquance of): the (CISCNIA) use ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably Wunknown 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy has 1 Yes 25 No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Was casa rafarrad to medical examinar? funeral director, Be 28. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury at Work? Dete of Injury (Month, Dey Year) 27. Mannar ot Death 28b. Tima of 284. Describe how injury occurred 5 Pending invastigation 1 Natural 1940 1 Yes 2 Accident 3 Sulcida 13 1999 tell dougstairs Placa ot tnjury - At homa, tarm, straat, tactory, offica building, etc. (Specify) 6 Could not be 28t. Location (Street and Number of City or Town, Stata) 2.600 Rural Route Number, 4 Homicide SIVE SPING, State) 26965 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifian 29c. Licensa number 29d. Data signed (Month, Day, Year)

Registrar

29b. Signature and titla of certifia

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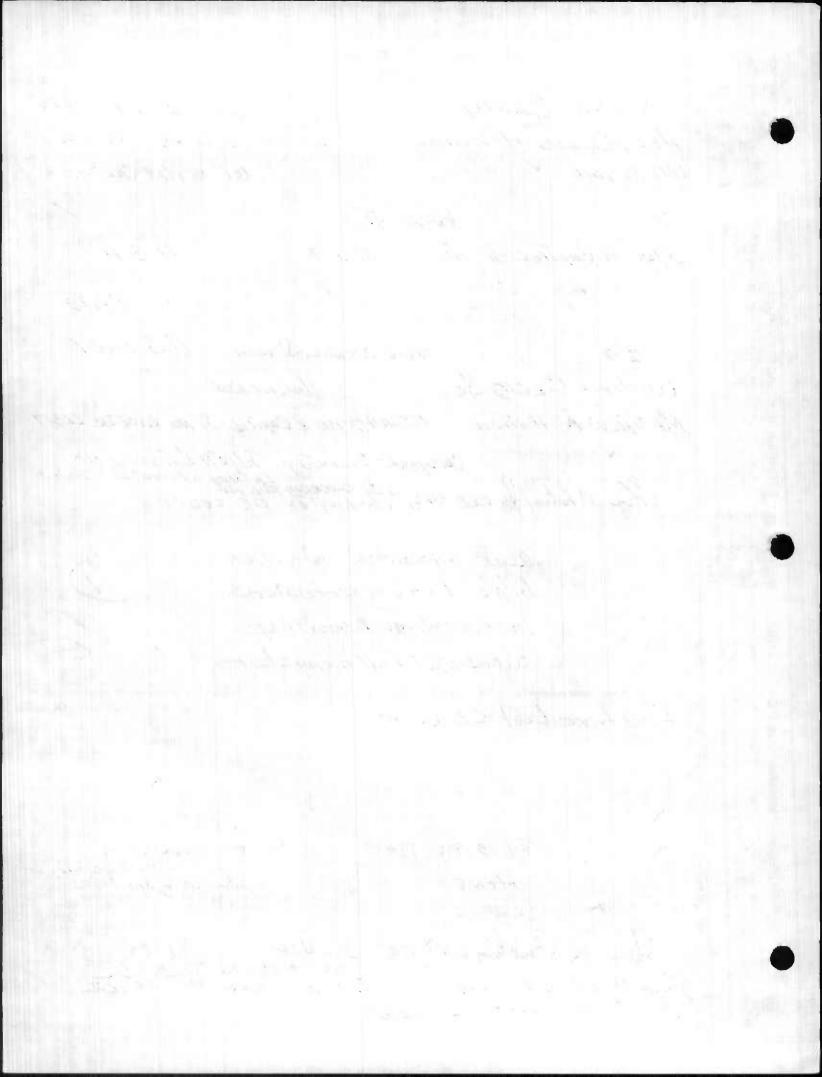
32. Registrar's Signatura

BRECHER

1 e and addrass of person who completed cause of death (item 23a) (Type, Print) 2/0/ Mebical

BOK

SILVER SPRING,



Physiciar /Medica Examine

Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burist-transit

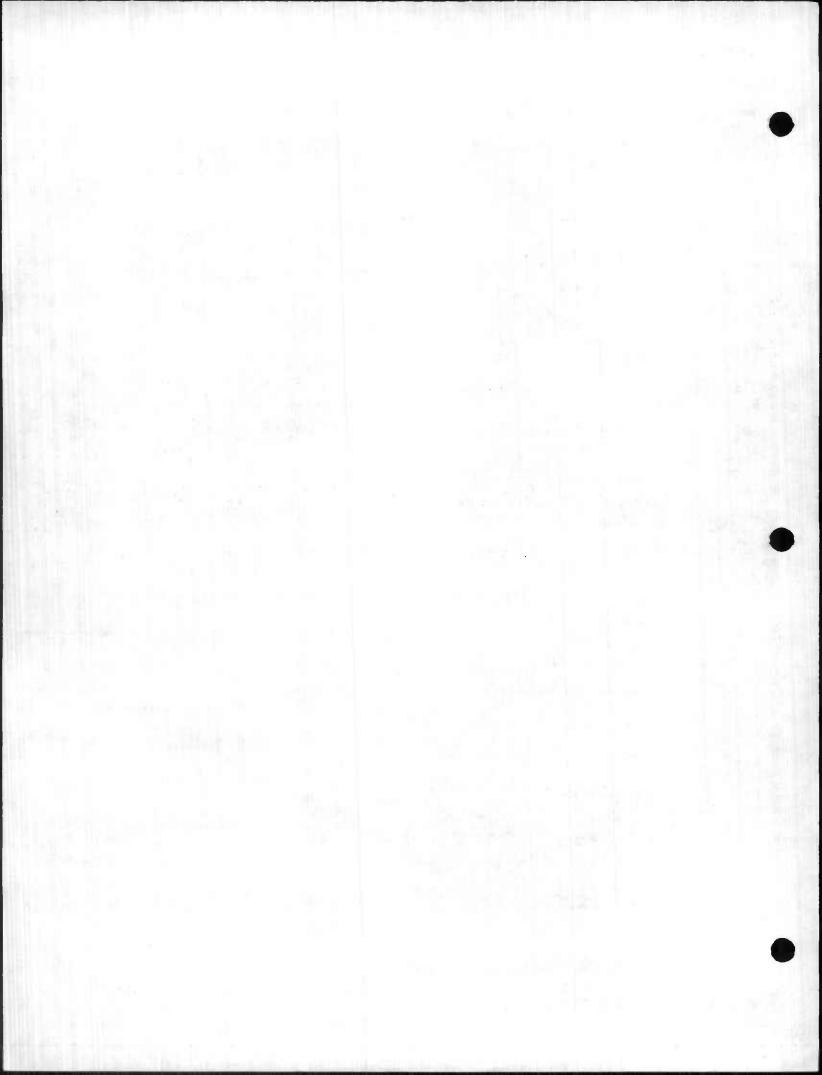
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1. Decedent's Name (First, Mi MIRIAM M.	iddle, Last) ARGAR	ET	GOLDB	ECK		13			2. Dete Monti		Dey	Year	3. Time of Death
4a Facility Name (If not institu			mber)				4b. City, T	own, or	Augu Location of		tc. County	-	8:43 A.M
Johns Hopkins				Conto	_		Balti	more					
5. Social Security Number	6. Sex	TCM I		s. last birthday) If Und	ler 1 Yeer	If Unde	r 24 Hrs	8. Dale	of Birth	N,	9. Births	plece (Stete or Foreig
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Usual Residence of Decedent			140.00									-	
10a. Stete 10b. Cou				City, Town or L								1	10d. Inside City Limits
	/A		В	ALTIMO									1 N Yes 2 N
10e. Street and Number 420 S. EAS	m 357E				10f. Z	Zip Code	224				Citizen of \ SA	What Cour	ntry?
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17. Father's Neme (First, Midd	die, Last)						18. Moth	er's Ner	me (First, M	iddle, Maid	en Sumen	ne)	
		GOLD	BECK				ELI	ZAE	BETH	WRIGI	HT		
19a. Informant's Name/Reletic	onship (Type	, Print)		19b. Mell	ling Addre	ss (Stree	t and Numb	er or Ru	urai Route N	umber, City	y or Town,	Stete, Zip	Code)
ANTHONY GOL	DBECK	/HUS					AVE	. ,	BALT				
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State Registrar Dennis Chute M.D.

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1999 11:30 PM ALFRED GNEITING AUGUST 25. /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 207 NANCY AVENUE LINTHICUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Days 218-18-4070 Yrs. Director JAN. 9, 1924 MARYLAND Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes XXNo ANNE ARUNDEL LINTHICUM Director MARYLAND 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 207 NANCY AVENUE 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1X Yes 2 No 1944-If Yes, Give Yeer or Deles: 1946 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 8 1 Yes 2X No Specify: WHITE Specify 5 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) 10 SUPERVISOR OF MAINTENANCE WESTINGHOUSE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 99 MATTHIAS GNEITING LOUISE DURR 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH E. GNEITING (WIFE) 207 NANCY AVENUE, LINTHICUM, MD. 21090 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Date Department of H Important: If its any injury or of cemetery, cremetory or other place) XX Burial 2 Cremation 3 Removel from Stete MEADOWRIDGE MEMORIAL PARK 8/28/99 ELKRIDGE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Finel /Medical · MYOCARDIAL disease or condition resulting in deeth) INFRACTION **Examiner** Due to (or es a consequence of): CAMPIO VOSCUM AT HBAUSCLIBAUTIC The law requires that the death certificate be assecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): MISHASI 68760. Physician/Medical Due to (or as e consequence of) Box P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Records, ate has been signed page 2 should be 24b. Were sutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifica director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To funeral 27. Menn of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? Division Neturat 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined in by t 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29e. Certifier Descripting Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner steled.

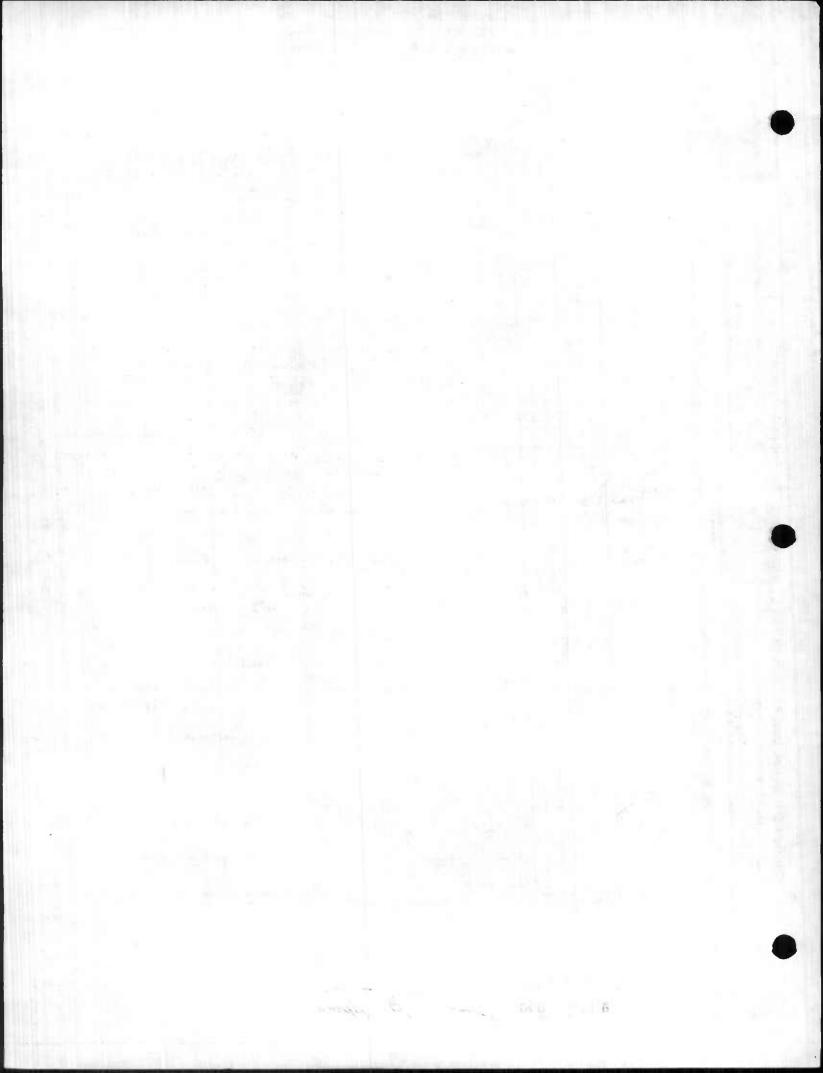
□ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. To the I within 2 29b. Signature and fifte of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar SIS CAME DRAMMERUAD; LINITH (UM,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

SHAVERS,

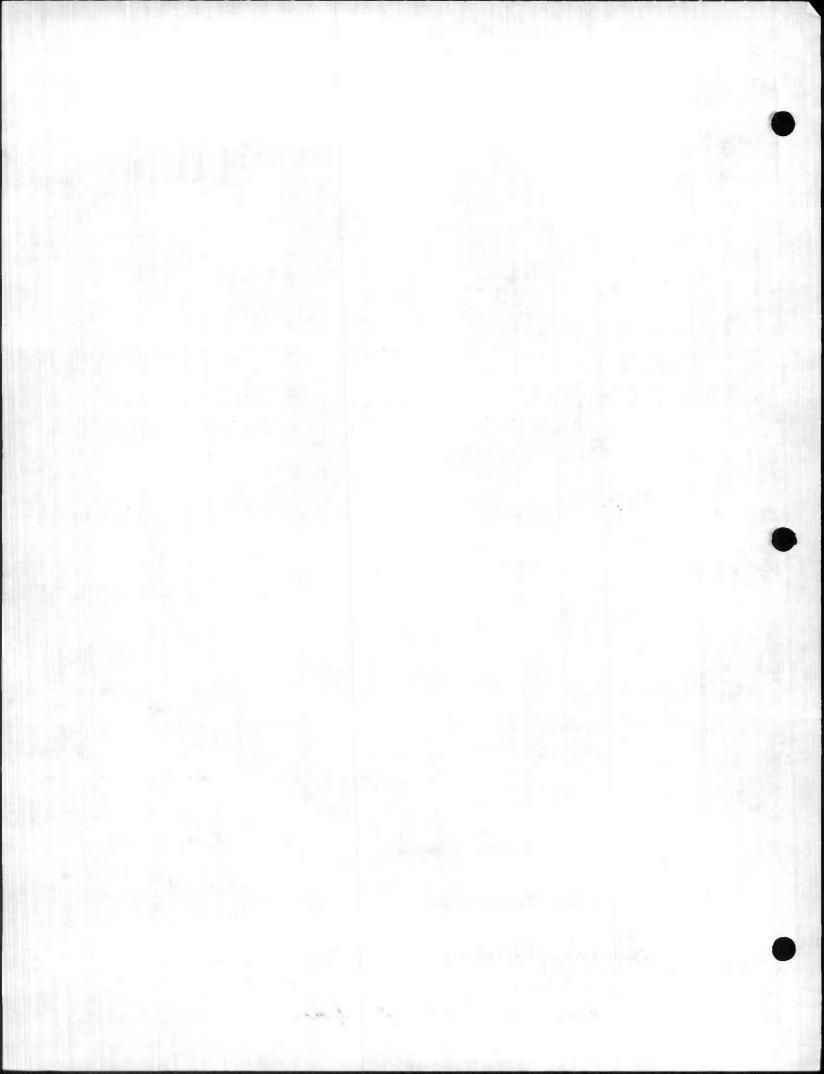


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NELSON	
GOSNELL	

GC	SNELL		Cert	ificate of	9 9	26956					
	Physician	1. Decedent's Name (First, Middle, La.					2. Date of D Month		Year	3. Time of Death	
	/Medical	Nelson M. Gosi					AUGUST			4:40P.M.	
	Examiner	4a Facility Neme (If not institution, given 3507 BEACH ROAD	e street and number)			4b. City, Town, or ESSEX	Location of Dea		of Death	RE	
	Funeral Director	217-60-0955	ex 7. Age (In yrs X M 2□ F 45	lasi birthday) Yrs.	Months Days		8. Date of B (Month, D	irth ley, Year) /53	9. Birtho Coun Balto	lace (State or Foreign of try).	
pus	Bu	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loca	ation				1	0d. Inside City Limits	
ha Mary	or 28a-f show be notified at Director	Maryland Baltimor	e Bal	timore	100 70 000			40-00	*****	1 Yes 2 XNo	
death with the Mandand	23a or Mal be or	3507 Beach Road			10f. Zip Code 21220			U.S.A.			
Maryland 21215-0020	Fur by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		les Decedent of Yes, specify Cul	Hispanic Origin? (S ben, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	Specify	ck, White, o	etc.	
5 5		15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decede (Give ki	nt's Usual Occu	ipation during most of wor	rking	16b. Kind of B	usiness/Inc	Justry	
121	mag du	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done during most of working b. DO NOT use retired)			11-1			
0 2	Tes e	12 yrs. 17. Father's Neme (First, Middle, Last)	3 yrs.	Station	Stationary Engineer 18. Mother's Nam			Univers e, Maiden Suman		00	
/lan	Mantal H srked ob site ever To Be	Lawrence L. Gosn				Gloria					
ary	DEE	19a, Informant's Name/Relationship (•	19b. Mailing	Address (Stree	et end Number or Ru		ber, City or Town,	State, Zip	Code)	
, M		Gloria Gosnell	(Mother)	11683	Cedar L	ane Kir	ngsville	e, MD. 2	1087		
0 -	imore, Pages 1 a nent of Hea int: If Item iry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State	Place of Disposi cemetery, crema rdens of			Dete 3/20/99	20c. Location -			
Balt	Departments any injury pages.	21. Signature of Funeral Service Line		E. 22.	Name and Addr F. Lass	ess of Facility Sahn Fune:	ral Homo	e			
		23a. Part1. Enter the disease, or compshock, or heart tailure. List only	plications that caused the dea	th. Do not enter	750 Bela the mode of dy	air Road	Kingsv:	ille, Ma	rylan	Approximete	
1	nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	. Har	ra ing					1	triferval Between Onset and Deeth	
Box 68760, C	ng physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in death) Last	c	or es a conseque							
		Part II. Other significant conditions or	dontributing to death but not re-	sulting in the und	derlying cause g	iven in Part I.	23b, Dio	i tobacco use co	entribute to	the cause of death?	
B, P.O	igned by the side of the side								1 □ Yes 2 No 3 □ Probe		
Records, P.O	2 should								COI	ere autopsy findings ellable prior to mpletion of cause death?	
C 2	- 6 -						1 Yes 2 □ No		12	Yes 2□ No	
of Vital	certificate rector, pag Be Co	25. Wes case referred to medical examiner?			I.	26. Place of Dea	ath (Check only	one)			
Of \	T BE	1 XYes 2 No		ER/Outpatient	3LI DOA			sidence 8 Oth		Y)	
Vision of Attending P	deeth. ctor: After t y the funer fleation:	27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation	m. r. m. m. M	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				28d. Describe how injury occurred self inflicted hanging			
Division of Attending	ns after deeth. al Director: After t ed in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					281. Location (Street and Number of Rural Route Number, City or Town, State) 3507 Beach Rd			
• Hospital	Puner taly fill	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowlene: On the besis of examination and manner stated.	owledge, death o	occurred at the t	ime, date and place opinion, deeth occu	, and due to the	ceuse(s) and me, date and plece,	enner as st and due to	ated. the cause(s)	
To the	To the comp	29b. Signature and title of certifier	100,			ise number		29d. Date signe			
	16	30. Name and address of person	completed cause of death (Ite		rint)	C.M.E.		AUGUST			
	-	Dennis J. (1) 31. Date filed (Month, Day, Year)	hute mo 32. Registrer's Sign		11 Penn	Street,	Baltimo	re, Mary	land	21201	
	State Registrar	AUG 2	7 1999 D _ ine	ve p	9. do	all					

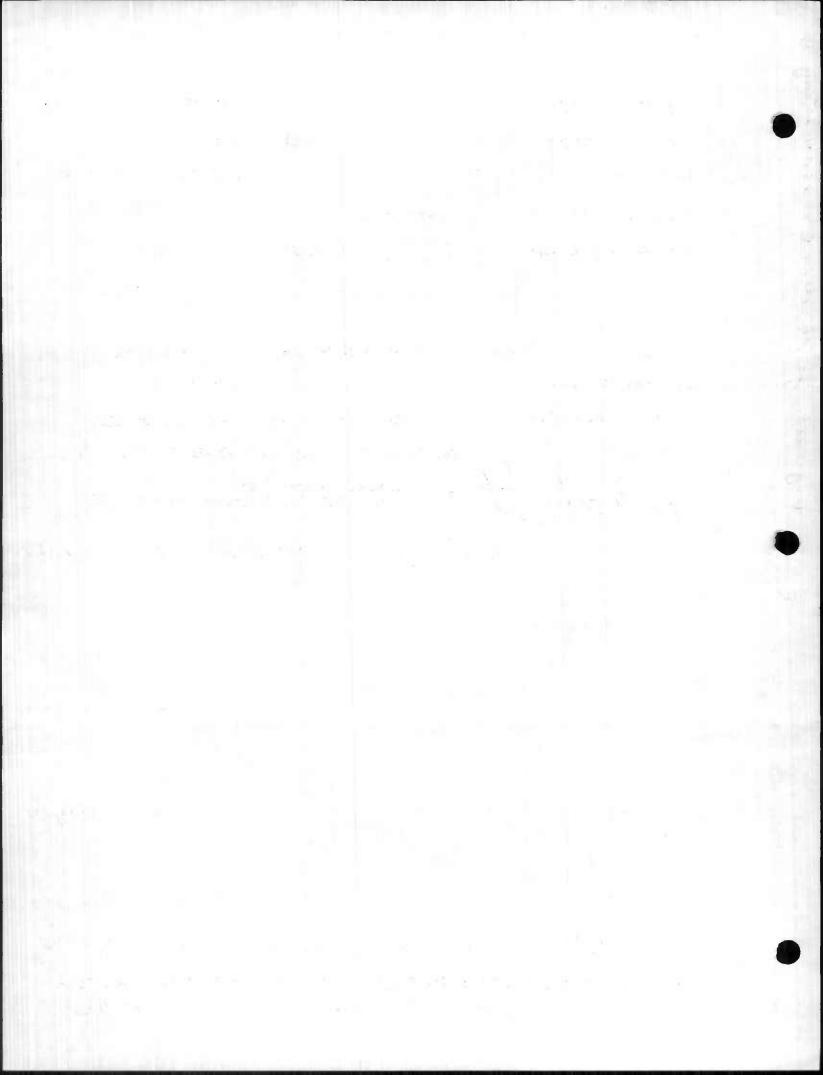


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAUGUST 25 1999 **Physician** JOSEPH A. GAGLIARDI 12:25AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) **Examiner** MR BALTIMORE COUNTY BALTIMORE GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 23,1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 10X M 2□ F Yrs. Director 74 219-16-5241 12:25 Maryland Usual Residence of Decedent Manyland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Baltimore Perry Hall 1 Yes 2X No eu 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 8751 Magnolia Avenue 21128 USA Herna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decadent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or item White Specify: 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 yrs. 3 yrs. Chemical Techncian Allied Signal 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. Joseph Gagliardi Lillian Marie Lucas 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernardine M. Gagliardi or other tr 8751 Magnolia Avenue Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Church Cemetery 8-28-99 Fullerton, Maryland 20a. Mathod of Disposition 1 ☑ Burial , 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Ligenses 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland what causad tha death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, Approximata Intarval Batween Onset end Death Physiclan O Steo SAVCOMA fmmediata Cause (Final months disease or condition rasulting in daath) **Examiner** Due to (or as consequance of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in daath) Last Due to (or as a consequance of): be axed 68760 Physician/Medical Due to (or as a consequence of) Box (P.O. Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, þ Pe 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No Vital Be 25. Was casa raferred to medical 26. Piaca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 8 NOther (Specify) Hos pico 1 Yes 2 No 2 of this 28c. Injury at Work? 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftar Division or Attending 1 Natural 2 Accident 5 Pending investigation rector: 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicida 24 hours Certifying Phyalolan: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier To the Hosp within 24 hou To the Funer completely fi (Check only one) 29g. Date signed (Month, Day, Year) Hugust 28, 1999 29b. Signature and title of certifie 29c. License number plated causa of the (Itam 23a) (Type, Print) N. Anthony Riley M.D. Gilchrist Center 6601 N. Charles St. Balto., Md. 21204 31. Date filed (Month Pray 2) en 32. Registrar's Signature

DHMH 16 Rav 6/95

State Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

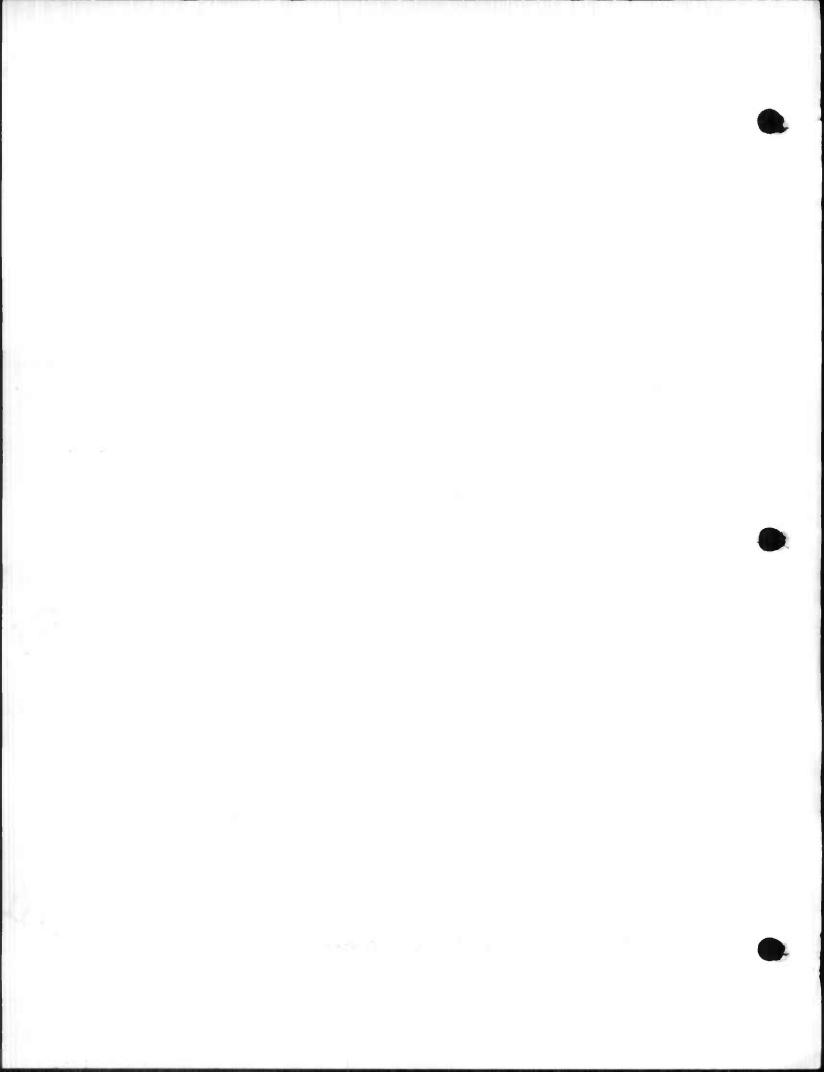
IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

-	TIEGIOTITATI		<u> </u>		OAIL	. 01	DLA		nc	G. NO.			
	1. DECEDENT'S NAME (First, Middle, Las James Gordon								2. DATE OF DE	ATH DA	š, 19	YEAR	3. TIME OF DEATH 8:05 a.m. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	historia a	IF UNDER	4 4510			August	_), I		
	218-34-4024	1 X M 2 - F	YRS.	MONTHS	de DAYS HOURS MIN. June 21,				1,19	934 s. BIRTHPLACE (State or Foreign WV		IPLACE (State or Foreign y) WV	
~	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN	OR LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
5	14538 Bain Road Hancock Washington												ton
D D	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											104 INSIDE CITY	
DIRECTOR		nington		На	ncoc	_							LIMITS?
FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 14538 Bain Road USA											YHAT COUNTRY?	
S	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARK	MED		NAS DEC	ENDENT O		IC ORIGIN? (Spe			14. RACI	E American Indian,
BY F	3 Wildowed 4 Diversed IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: Specify:												
	15. DECEDENT'S E	DUCATION	18a. DEC	EDENT'S	USUAL OC	CUPATIO	ON		16b. KIND	OF BUS	INESS/IND	USTRY	WILLCE
COMPLETED	(Specify only highest gra	College (1-4 or 5	life .	ne kind of w Do NOT us	rork done d e retired.)	furing mo	est of workin	9	11.00				
린	7		Me	echar	nic				Ret	ai1	Auto)	
S I	17. FATHER'S NAME (First, Middle, Last)	-					16. MOTH	IER'S NAM	ME (First, Middle,	Maiden S	Surname)		
BE (Lester Gantt								Miller				
2	190. INFORMANT'S NAME (Type/Print) Cora E. Gantt/W.	ife							oute Number, City			Code)	
	20s METHOD OF DISPOSITION 1 Burtel 2 Cremetion 3 Re	moval from State	20b. PLACE A cemetery, cren	netory or oti	her place)						ATION —		
- 1	22. NAME AND ADDRESS OF FACILITY												
	Grove Funeral Home, P.A. 141 W.Main St.Hancock, MD 21750-0368 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate												
	23. PART I. Enter the diseeses, o shock, or heart failure	complications the	t caused the dec	th. Do n	ot enter	the mo	de of dyl	ng, such	ss cerdlec o	r respir	atory err	est,	Approximate
- 1	IMMEDIATE CAUSE (Final												Onset and Death
	immediate cause (Final disease or condition resulting in death) a. Laryngeal Cuncer with metastases to lung Due to (or as a consequence of): and spind												
	Property of Tables,	DUE TO	(OR AS A CONSEO	UENCE OF):				d	nd	SPI	nd.	
8	Sequentially list conditions,	b									97		
Ě	if any, leeding to immediate cause. Enter UNDERLYING	DUE 10	(OR AS A CONSEO	UENCE OF);								
윤	CAUSE (Disesse or Injury that initieted events	c. DUE TO	(OR AS A CONSEO	UENCE OF):						_		
CERTIFICATION	resulting in desth) LAST	2			•								
5		d											
DICAL	PART ii. Other significent condition							lven in I	Part I. 24s. V	ARS AN A	WTOPSY MED?	24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8	chionic ob	structive	pulmon.	ury	d	ise.	450		_ 1 _	YES 2	Q NO		OF DEATH?
ME													1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CON	TRIBUTE TO CA					UNC	ERTAIN					
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	OTHER								
<u>≥</u>	1 YES 2 NO 27. MANNER OF DEATH		ER/Outpatient 3	DOA 28b. TIME	4 🗌 Nurs	ing Hom	a 5 Pa	sidence i	B Other (Spec	-			
	1 Natural 5 Pending	28a. DATE OF (Month, D		INJU			VRY AT	1.00	28d. DESCRIBE	HOW IN	JURY OCC	CURED	
B	2 Accident Investigation		F INJURY — At hon	ne form e	troot facts			NO	201 LOCATION	(Street or	-d A1	0 1	
	3 Suicide 8 Could not b 4 Homicide determined	bullding,	etc. (Specify)	ro, rorri, a	treet, racto	му, отпс	•		City or Town	(Street ar	na Number	or Hural F	loute Number,
9	29e. CERTIFIER												
COMPLE	(Check only	SICIAN: To the best of second) and menner se stated.
шШ	296. SIGNATURE AND TITLE OF CENTER	ER) 1					29c. LICE	NSE NUM	BER	T	29d. DATE	ESIGNED	(Month, Day, Year)
	4						1730	584	1		18	1/24	1/99
	30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)	1 _		, .			7		
	TOTAL OF	anspoon, N	10 ; 130) W.	Hig	h 5.	4. "	Han	cock,	MS	2	1750	7
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE	1.	1								
	AUG 2 7 199	19 100	ou p	7.	space	Ks	/						
					-								DMMH 10 Ben 1/00



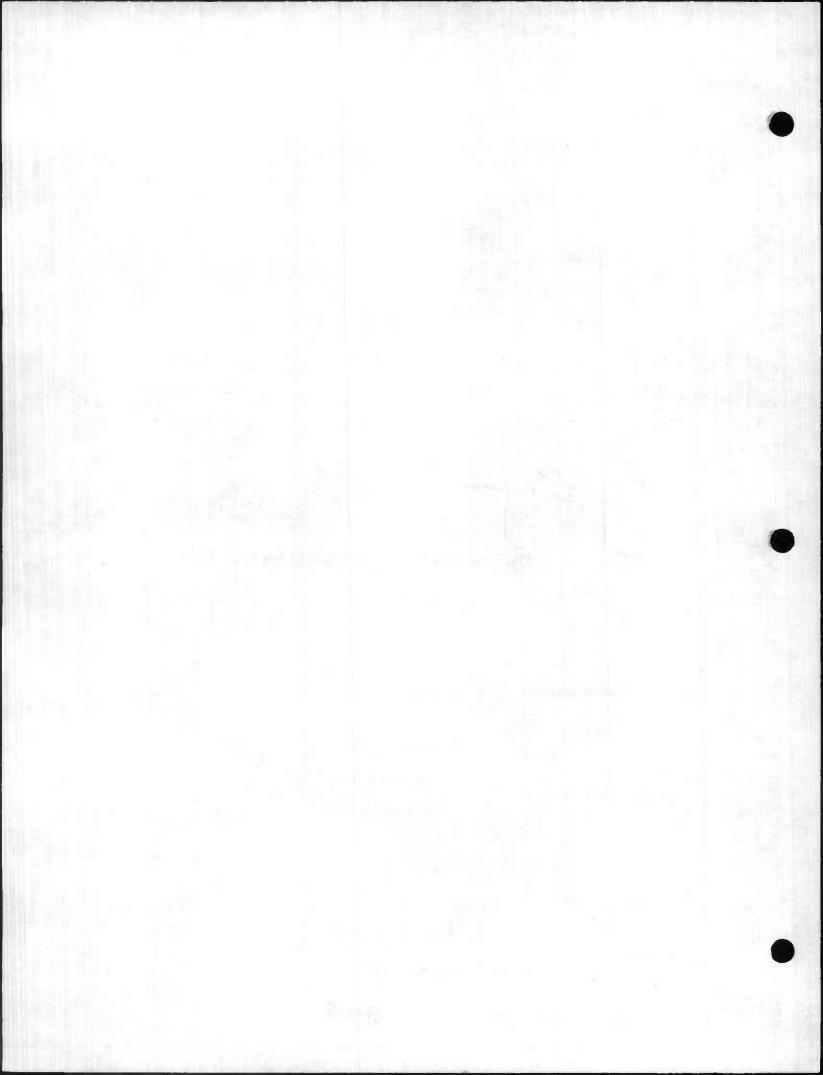
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Day Month **Physician** August 25, 1999 5:45am Margaret Hanauer /Medical 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sunrise of Towson Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Min. Hours 1□M 2₩F 97 Director 220-54-7298 July 21, 1902 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Director 288-7 Maryland Baltimore Towson 2 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n 7925 York Road 21286 USA Funeral Thomas: 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Medital Status Black, White, etc. Pages 1 and 2 should be Illed within 72 hours ather near of health and Merital Hydiens.

Tit If them 27 is marked other than "natural, or the rity or other traumed event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 21215-0020 1 Yes 2√ No Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 N/A Homemaker Own Home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Burker John Eliza Jane (Unknown) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Robert W. Hanauer/Son 221 Burning Tree Road, Timonium, MD 21093 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or ance. 4 Donetion 5 Other (Spec Baltimore National Cem. 8/27/99 Baltimore, Maryland 21. Signature of Funerel Service Local 22. Name end Address of Fecility Lemmon Funeral Home Timonium, MD 10 W. Padonia Road, 21093 Clary 23a. Pert1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Frial disease or common resulting in death) Arteriosclewic Cardiovascula kaus Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Last Due to (or as a consequence of): and Box 68760. physician Physician/Medical eun Due to (or as a consequence of): 88 for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy peeu page 2 this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No of Vital Attending Physician: funeral director. 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Legical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely the state of Signature and title of certifier 29e License number 29d. Date signed (Month, Day, Year) August 26, 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd., Balto., MD 21239 Edward Miller, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State rocks Registrar AUG 2 7 1999

AHB



32. Registrar's Signature

AUG 27 1999

DHMH 16 Rev 6/95

State

Registrar

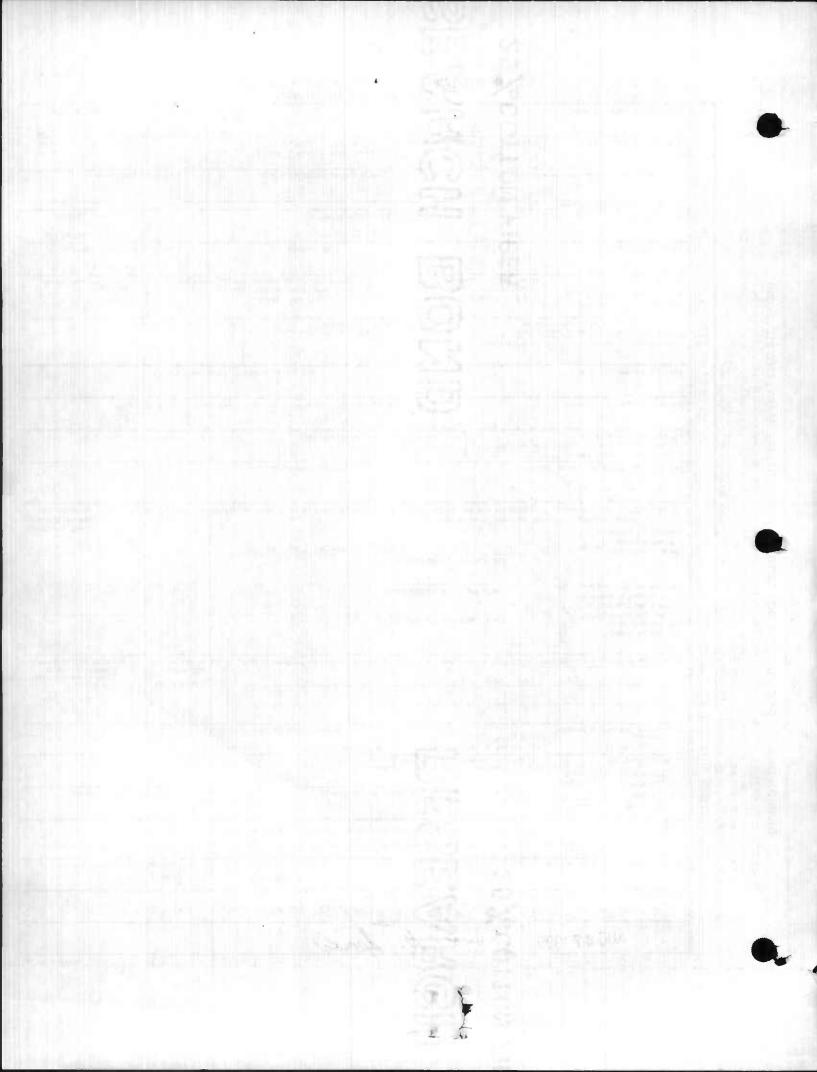
Seeply Weller

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1 - STATE REGISTRAR	STATE OF N	IAHTLANU /	ERTIFICA	TE OF DE	ATH	MENIA	REG. NO	_		
1. DECEDENT'S NAME (First, Middle,		HOLECT				MONT		MY Y 20 199	EAR	TIME OF DEATH
4. SOCIAL SECURITY NUMBER 235-12-6534	5. SEX 1 M 2 XXF	8. AGE (In yrs. let 85			INDER 24 HRS.	7 DATE	OF BIRTH		BIRTHPLA	CE (State or Foreign Virginia
Future Care Ca	anton Harbon	r Center		altimor		DEATH	9c. COUNTY OF DEATN N/A			
	ounty altimore		Baltim	n or Location					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 9914 Foxhill 1 11. MARITAL STATUS 1. Never Married 2 Married	Road	die		10r. 2IP	128					COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 21		IS. WAS DECENDED If yes, specify 1 YES 2	Cuben, Mexic	can, Puerto		s or No 14	Black, W	American Indian, hite, atc.
15. DECEDENT' (Specify only highes Elementary/Secondary (0-12) UNKNOWN 17. FATNER'S NAME (First, Middle, Li	S EDUCATION t grade completed) College (1-4 or 5 -	(C)	ECEDENT'S USUAL Two kind of work do a. Do NOT use retire Lomemake	ne during most of (d.)	vorking	160		Home	TRY	
17. FATNER'S NAME (First, Middle, La Unknown	not)	4000			MOTNER'S N Unkno		Middle, Meider	Surname)		
190. INFORMANT'S NAME (Type/Prin Juliana Jones	v)	33	B17 Putt	y Hill	Avenu	e Bal	ber Chy or Ton timor	vn, Stote, Zip Co	yland	21234
20a. METHOD OF DISPOSITION 1		20b. PLACE	AND DATE OF DISE	cosition/Name of	ory			Laurel,		
21. SIGNATURE OF PUNERIAL SERV	ICE LICENSEE					ACILITY	Dippe.	l Funer	cal E	ome Inc. and 2120
immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO b	STAGE (OR AS A CONSE		MER'S	DISE	ASE				12 YEAR
cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	CDUE TO	(OR AS A CONSE	OUENCE OF):							
PART II. Other eignificent con		death but not	resulting in the	underlying cer	use given i	n Part I.	24a. WAS AI PERFO 1 YES	RMED?	CO OF	RE AUTOPSY FINDING ILLABLE PRIOR TO MPLETION OF CAUSE DEATH?
	CAL			26. PLACE	OF DEATH (C	Check only o	ne)			
25. WAS CASE REFERRED TO MEDI										
25. WAS CASE REFERRED TO MEDI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	HOSPITAL: 1 Inpetient 2 Inpetient 2 (Month, D	INJURY	DOA 4 DOA 26b. TIME OF INJURY	Nursing Nome 5 28c, INJURY WORK?		_		INJURY OCCUI	RED	
2 Accident Investig	25a. DATE OF (Month, D) sation not be	INJURY lay, Year)	26b. TIME OF	28c, INJURY WORK?	AT	28d. DE	SCRIBE NOW	end Number or		Number,
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pendin Investig 2 Accident 3 Suicide 5 Could detarmined	g setion not be ined 25e. PLACE 0 building,	INJURY hey, Year) F INJURY — At hetc. (Specify) my knowledge, d	26b. TIME OF INJURY Nome, farm, street,	Nursing Nome 6 28c. INJURY WORK? 1 YES factory, office	2 NO	28d. DE 28f. LOC/h	SCRIBE NOW CATION (Street or Town, Stets use(e) end me	end Number or	Rural Rout	
2 Accident 3 Suicide 5 Could detarmi 29e. CERTIFIER (Check only one) 2 MEDICAL E 29b. SIGNATURE AND TITLE OF CE	g setion 26e. DATE OF (Month, D setion not be ined 26e. PLACE O building, PHYSICIAN: To the best of CAMINER: On the best of e	INJURY — At he stc. (Specify) my knowledge, department of the state o	25b. TIME OF INJURY Nome, farm, street,	Nursing Nome 6 28c. INJURY WORK? 1 YES factory, office time, date end my opinion, death	2 NO place, end de occured at the DIGG	28d. DE 28f. LOCAL City use to the case time, det	SCRIBE NOW CATION (Street or Town, Stell use(e) end m e end place, a	end Number or i) anner ee stated, ind due to the c	Rural Route	d menner ee stated.
2 Accident Investignment 3 Suicide 5 Could determine (Check only one) 2 MEDICAL E) 296. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL E)	g setion 26e. DATE OF (Month, D setion not be ined 26e. PLACE O building, PHYSICIAN: To the best of CAMINER: On the best of e	INJURY — At he stc. (Specify) my knowledge, department of the state o	25b. TIME OF INJURY Nome, farm, street,	Nursing Nome 6 28c. INJURY WORK? 1 YES factory, office time, date end my opinion, death	2 NO place, end de occured at the DIGG	28d. DE 28f. LOCAL City use to the case time, det	SCRIBE NOW CATION (Street or Town, Stell use(e) end m e end place, a	end Number or i) anner ee stated, ind due to the c	Rural Route	d menner ee stated.



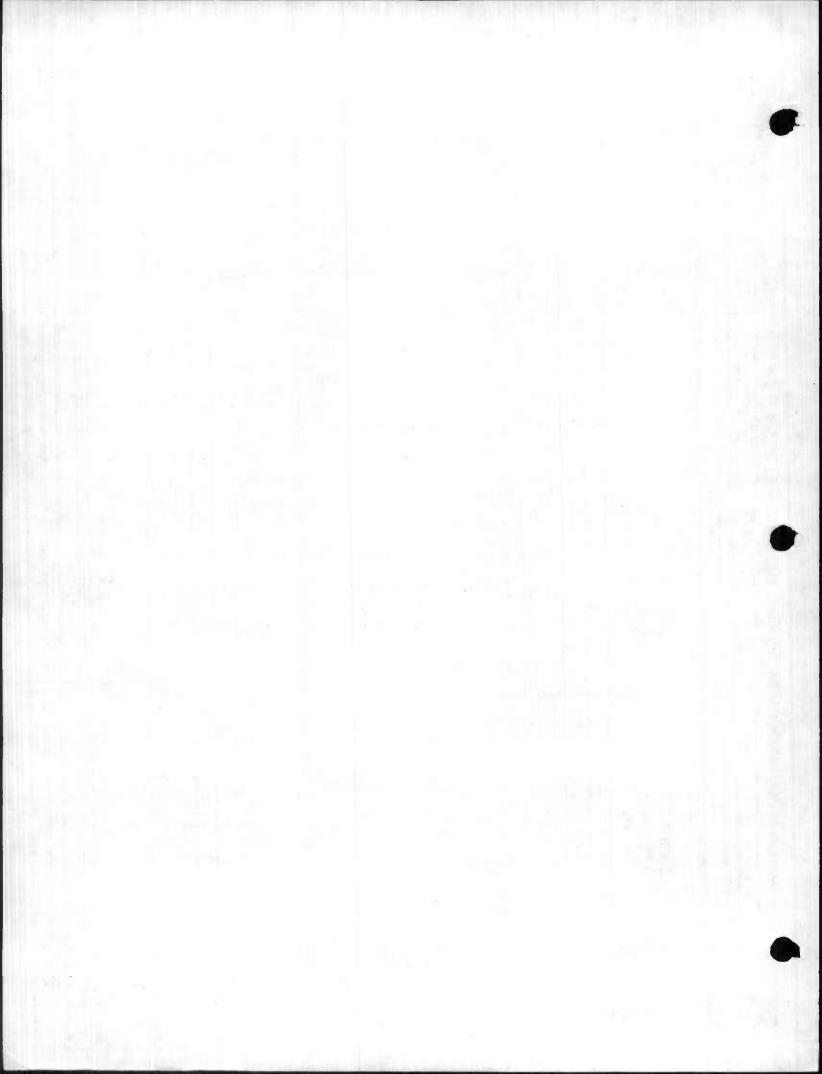




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		the second of	Certific	ate of Death	R	eg. No.	26962				
hysician	1. Decedant's Nama (First, Middla, Last, Havold	Michael	Hara	dy	2. Data of Deal Month AUGUST	Day 194	3. Time of Death				
/Medical xaminer	4a Facility Nama (If not institution, giva	street and number)		4b. City, Town, o	r Location of Death	4c. County of C					
Adminici	Johns Hopkins B	Bayview Med	dical Cen	ter Baltin	2761	N	A				
neral ector	219 00 1903	7. Aga (In yrs		der 1 Year If Under 24 Hi hs Days Hours Mi		Year) 1956	Birthplace (Stata or Forei Country) MD				
	Usual Rasidence of Decedent 10a. Stata 10b. County	10c. C	ity, Town or Location				10d. Inside City Lim				
/ Funeral Director	MD BALTIMO	ORE THE	NERS STATI	ON			1⊠Yes 2□I				
Director	10e. Street and Number	7KL TOK		Zip Code	1	0g. Citizen of Wha	t Country?				
0	116 CHESTNUT ST.			21222		77.C.A					
Funeral		12. Was Decedent Evar in U Armed Forcas?	J,S. 13. Was De	pecedent of Hispanic Origin?	(Specify Yes or No-		American Indian,				
þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yas 2 No If Yas, Giva X Yaar or Datas:		s 2 🖾 No Specify:	ento rucan, etc.)		White, etc. BLACK				
Completed	15. Decedant's Edu (Specify only highast grade	cation	16a. Decedent's L	Isual Occupation	ndring	16b. Kind of Busin	ess/Industry				
nple	Elementary/Secondary (0-12)	Collega (1-4or 5+)		work done during most of w T use retired)	- Cirking						
Co		3	COMPUTE	R TECH.		HOSPITAL	4				
Be	17. Fathar's Nema (First, Middla, Last)			18. Mother's N	ame (First, Middle, I	viaiden Sumama)					
To	JAMES HARDY		1		Y M. BRO						
	19a. Informant's Name/Relationship (Ty			ess (Street and Number or I							
6.7	LUCY M. HARDY/MOTH		116 CHES	STNUT ST. TURI		LON, MD. 20c. Location - City					
	1 Burial 2 ☐ Cramation 3 ☐ R	amoval from Stata	D. NATIONA	or other place)	8/31/99						
	4 Donation 5 Other (Specify)				1						
DUC	James a	Winter		TES ACTOM MORTON 1 LAURENS ST							
	23a. Pany. Entar tha disaasa, or compli	catimin that caused the daa					Approximate Interval Between				
н	23a. Pah. ⁷ . Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, stock, or heart failure. List only one cause on much line.										
hysician /Medical xaminer	Immediata Causa (Final disaasa or condition resulting in daath) a. Methicillin resistant staphylococcularumus bacteremia										
	rasulting in death) a. Mithillin its Stant Staphylololia audit of the mid										
iner			6 WILKS								
жаш	Sequentially list conditions,	Cryptoloccal Dua to	or as a consequence	of):							
edical Examiner	Sequantially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disaase or Injury	Acquired in	nmunode	ficiency sy	ndrome	31 7					
dic	that initiated avants rasulting in death) Last	Dua to (or as a consequence	of):							
		J					1				
Clar					1						
Physician	Part II. Other significant conditions con	tributing to death but not re-	sulting in the underlyir	ng causa given in Part I.			bute to the cause of dea				
by P					1 Y	es ZPCNo 3					
Completed b					24a. Was a perform		4b. Were autopsy finding available prior to completion of cause of death?				
E					1 🗆 Yı	es 2KNo	1 ☐ Yes 2 ☐ No				
	25. Was case referred to medical			26 Place of D	leath (Check only on		10103 2010				
To Be	axaminar?	lospital: 1 Inpatiant 2	☐ ER/Outpatient 3☐	Other	Homa 5 ☐ Reside		(Specify)				
	27. Manner of Death	28a. Data of Injury	28b. Tima of	28c. Injury at Work?		ow injury occurred					
ato	1 Accidant 5 Pending invastigation	(Month, Day Year)	Injury M	1 Yas 2 No							
Certification:	3 Suicida 6 Could not be determined	28a. Place of Injury - At h building, etc. (Special	noma, farm, street, fac fy)	tory, office	Street and Number or Rural Routa Number, wn, Stata)						
edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	lician: To the best of my known: On the basis of examination and mannar stated.	owledge, deeth occur ation and/or investigat	red at the tima, data and pla tion, in my opinion, death oc	ce, and due to the coursed at the time, d	ause(s) and manne ata and place, and	er as stated. I due to the cause(s)				
¥ e	29b. Signature and title of certifiar	A. P. Color and		29c. License number		9d. Data signed (A					
	30. Nama and addrass of person who co Suzanne M. Calla 31. Data filed (Month Day Year)	M. LALMAN	0	97401		Actorist	21. 1999				
	30 Name and Independent of the second of the	moleted cause of death (the	m 23a) (Time Drine)	11-186		nugust	20, 1-1-1				
	SUZANDI M. CALLA	MISI UGU	n Enction	ANNINE RA	1timen	Marula	nd 21220				
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	atura /	1100.101-		10/1/10/					
tate	31. Data filed (Month, Day, Year)	37. Hegistrar's Sign	atura 4	2.11							

Atte



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month John F. Harrison August 24, 1999 10:30 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Dave Hours Min. (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 1X M 2□ F Yrs. 70 218-26-5638 March 6,1929 Maryland Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2000 Maryland Severna Park Anne Arundel 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 269 Ross Landing 21146 United States 12. Was Decadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specity Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, White, afc. 1 Navar Married 2 Married 1% Yas 2□No If Yas, Giva Yaar or Datas: Korean 1 ☐ Yas 2 ☑ No Specify. Specify: 3 Widowad 4 Divorced White 15. Decedant's Educetion (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Printing Bureau of Engraving 12 Years 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Mildred Elizabeth Mobury Roland Henry Harrison 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 269 Ross Landing Severna Park, Maryland Mrs. Mae E. Harrison Wife 20b. Place of Disposition (Nama of cematary, cramatory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from State McKendree Church Cem. 8/28/1999 Howard Co., Maryland 4 Donation 5 Other (Specify) 21. Signature of Femaral Sarvica Licensea Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enfar fh r complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, only ona causa on each line arcinoma to liver Immediata Cause (Final disease or condition rasulting In death) Dua to (or as a consequence of) Sequantially list conditions, if any, leading to immadiate ceuse. Enter Undarlying Causa (Disaasa or Injury that initiated events rasuiting In daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying couse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ung Carcinoma 24b. Were autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Tyas 2 No 25. Was cese ratarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homlcide

The law requires that the death certificate be axecuted signed by the atte P.O. Records, page 2 has certificata Division of Vital Hospital or Attending Physician: funeral director. this Aftar after death. filled in by tha To the Hospital within 24 hours a To the Funeral C

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

Be

"netural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after or whort of Haalin and Mental Hygiena.

nn: if Item 27 is marked other than "netural, or ites ury or other traumatic event, in the way at Engine ury or other traumatic event, in the way at Engine.

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/Medical **Examiner**

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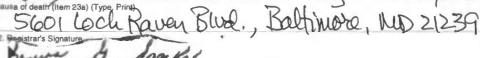
29a. Cartifier

29b. Signatura and titla of certifiar

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

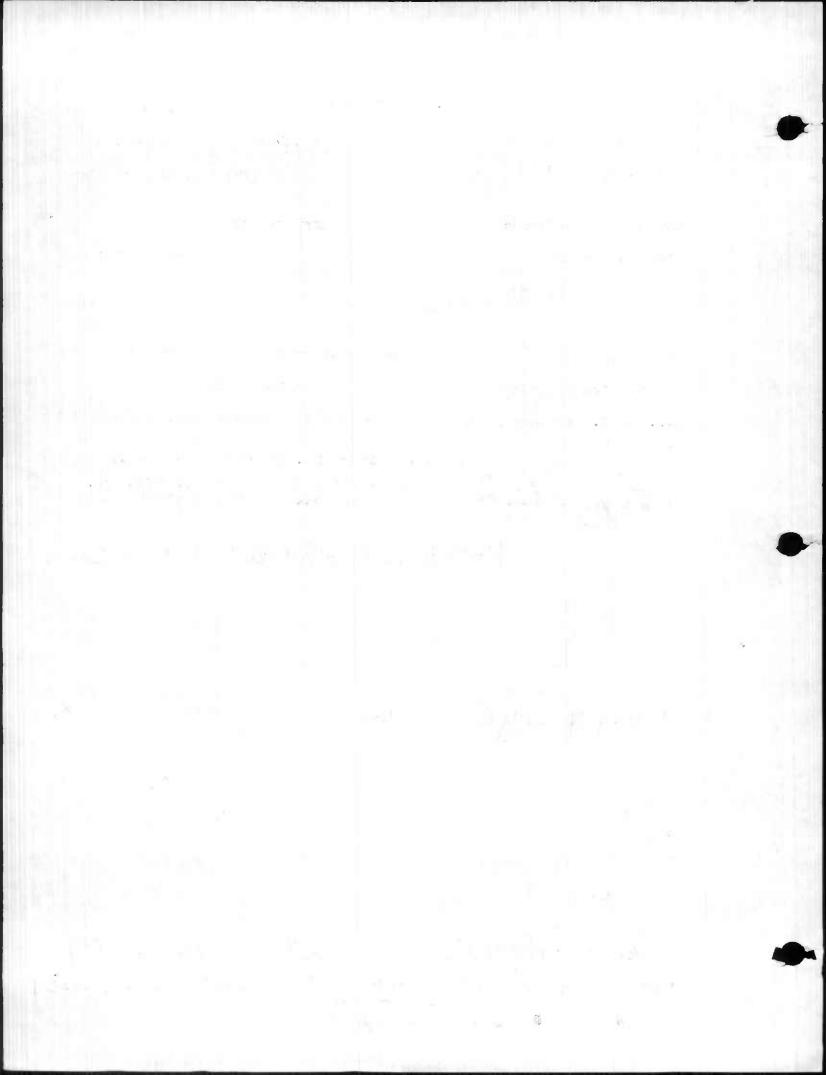


1/Lertifying Phyalcien: To tha best of my knowledge, daath occurrad at the time, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa numbar

29d. Data signad (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03:23 ANG 20 Charles /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Byyview Medical Baltimore Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** 1 M 2 F Months Days Hours Min Yrs. **Director** 215-40-2088 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIMODE MD NOTINGHAM or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Berns 23a U.S.A. Funeral 101 6 JULIET 21736 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 ò 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 'natural'. WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Coilege (1-4or 5+) Eiementery/Secondary (0-12) WAGE COMMISSIDA CITY OF BALTIMORE 12 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) of bend Mantal F Be OL CARL E. HAVE CATHERINE ITARLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is 12TH BAUTHORE MVE. MD. 21234 THOMAS HAUF BEOTHER 9520 Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MUG. 23, 1 Buriel 2 Cremetion 3 Removel from State ö 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland NON CATTEDRAL COMETERY 1999 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNDEAL CHAPEL any in Days Christine Hardesty 8800 HARFORD RD. PARKVILLE , MD. 21234 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final -days Respiratory disease or condition Examiner Examiner 1010 Total Body Surface Area Burn with Inhalation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-tran Due to (or es e consequence of) pue certificate be execu physician the burial Box 68760 Physician/Medical Due to (or as a consequence of) 88 USB 23b. Dtd tobacco use contribute to the cause of death? Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed paga 2 1 Yes 2 No 1 TYes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Sanpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1⊠Yes 2□ No this funarai 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27 Manner of Deeth 28h Time of 28c. tnjury at Work? Certification: Attending 5 Pending investigation 1 Netural 9:41 A M 1 Yes 2 No Patient pured publing EtOH on self-then ignite 281. Location (Street and Number or Rural Route Number, City or Town, State)

BALT. Hd 21236 24 hours after death. 16 1999 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by ò Home Hospital 29e. Certifier 📆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner as steted. To the Hosp within 24 hor To the Fune completaly fi Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigation, In my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 20

DHMH 16 Rev 6/95

State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) #407

Thames

Baltimore

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Year **Physician** harles Richard 1999 AUGUST 26, 12:15PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 20 F 215-30-1318 Director arvian Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. fnside City Limits orunn: n nem 27 is marked other than "natural", or hama 23a or 28a-f show Injury or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director IMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 DXyes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter a Depertment of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or her eny Injury or other treumatic event 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) General Motors College (1-4or 5+) Autoworker 12 Vrs Hosthaus, 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Holthaus Ackerman Eleanor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) haus/Wife 2459 Ellis Rd. Parkville, MD 21234 Marion J. Holt 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 8/30/99 Parkville, MD. Moreland Memoria 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funerel Service Licensee Evans Chapel of Memories Harford Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 4 months disease or condition resulting in death) Examiner Examiner attending physician and for use as the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes BONO Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To Mpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after deeth. To the Funerel Director: After Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. [2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only one) 29b. Signature and title of certifie 29c. License riumber 29d. Date signed (Month, Day, Year) cland, mp

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State Registrar DHMH 16 Ray 6/95

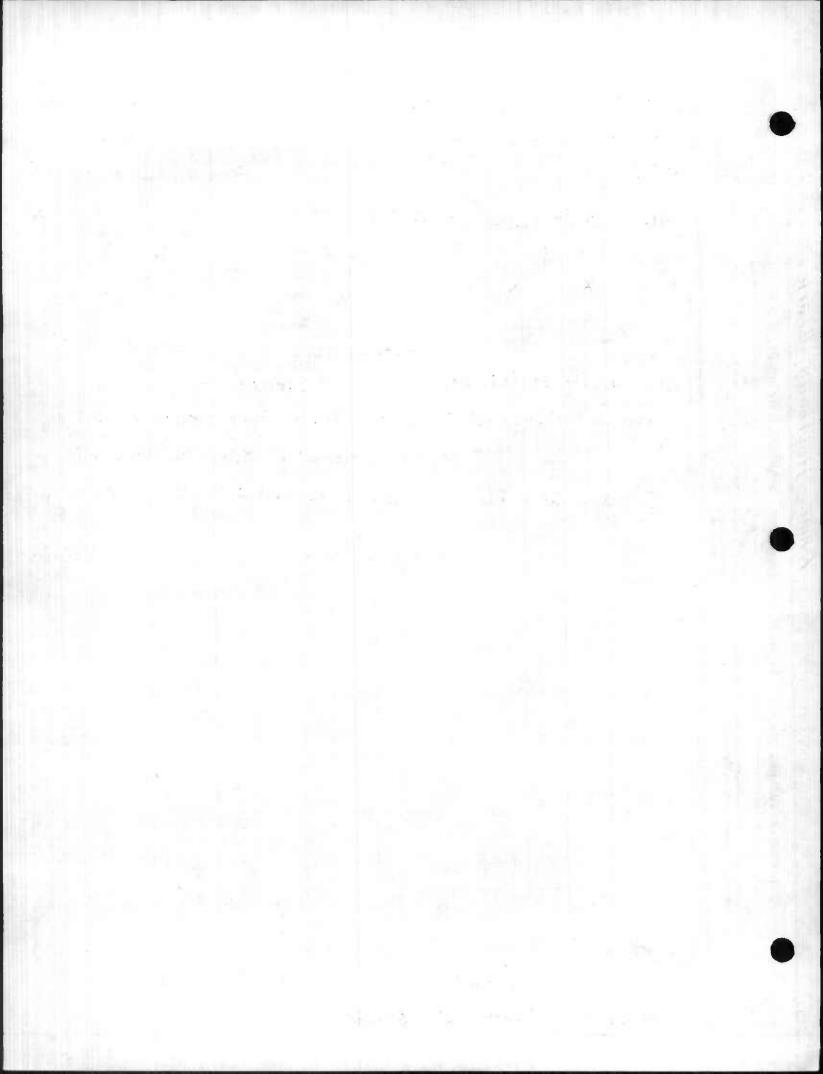
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL (EZAWO 656)W, Charles 57

32. Registrar's Signature

31. Date filed (Month, Day, Year)

8/26/1999

BALTIMOR, M 21204



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** Dreama Alice Jones August 26
4b. City, Town, or Location & Death 4c. Cou 1999 5:15 P.M. /Medical 4a Facility Nama (II not institution, give street and number) 4c. County of Deet Examiner 7. Aga (In yrs. last birthday) Center BATIMORE SEUARE dAle ose If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar Months Days 5. Social Security Number 6. Sax Birthplaca (State or Foreign Country) **Funeral** Days 1 M 200 216-26-7625 Director March 18, 1932 West Virginia Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ! Maryland Baltimore 1 Yas 2 No Essex 'natural', or items 23s or 28s-f 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? U.S.A. 680 Middlesex Road 21221 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Never Merried 2 ☑ Merried 1 Yas XXNo If Yas, Give Year or Detes: 21215-0020 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Bus Attendant Balto.Co. Schools altimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Jesse Wesley Lafon Mary Alice Bryant 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Ann Paul (daughter) 1263 Rivermark Court, Lawrenceville, Georgia 30043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 8/28/99 Baltimore, Maryland Holly Hill Mem. Gardens 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Segrice Licenses 22. Name end Addrass of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Batwaen Onset and Death **Physician** /Medical Immediata Cause (Final HemoRRhage · SubARACHnoid DAYS disease or condition rasulting in death) Examine Due to (or as a consequence of) Examine Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disease or Injury that initiated evants rasulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Completed by Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown heart Failure Deep Venous Thrombosis Records, 24b. Were autopsy findings available prior to 24s. Was an autopsy performed? Hyperlension completion of causa of deeth? RheumaToid ARTHRITIS 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case rafarrad to medicel axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medicai Certification: To this 27. Mennar of Death 28b. Time of 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? Affer Attending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun Netural 5 Panding 1 ☐ Yas 2 ☐ No investigetion 2 Accident 6 Could not be detarmined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifian (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signeture end titie of certifie 30. Nama and address of person no completed ceuse of deeth (Item 23a) (Type, Print) SquareDR. BALTIMORE, MARYLAND PeldRo FRANKlin AMAdOR 1000

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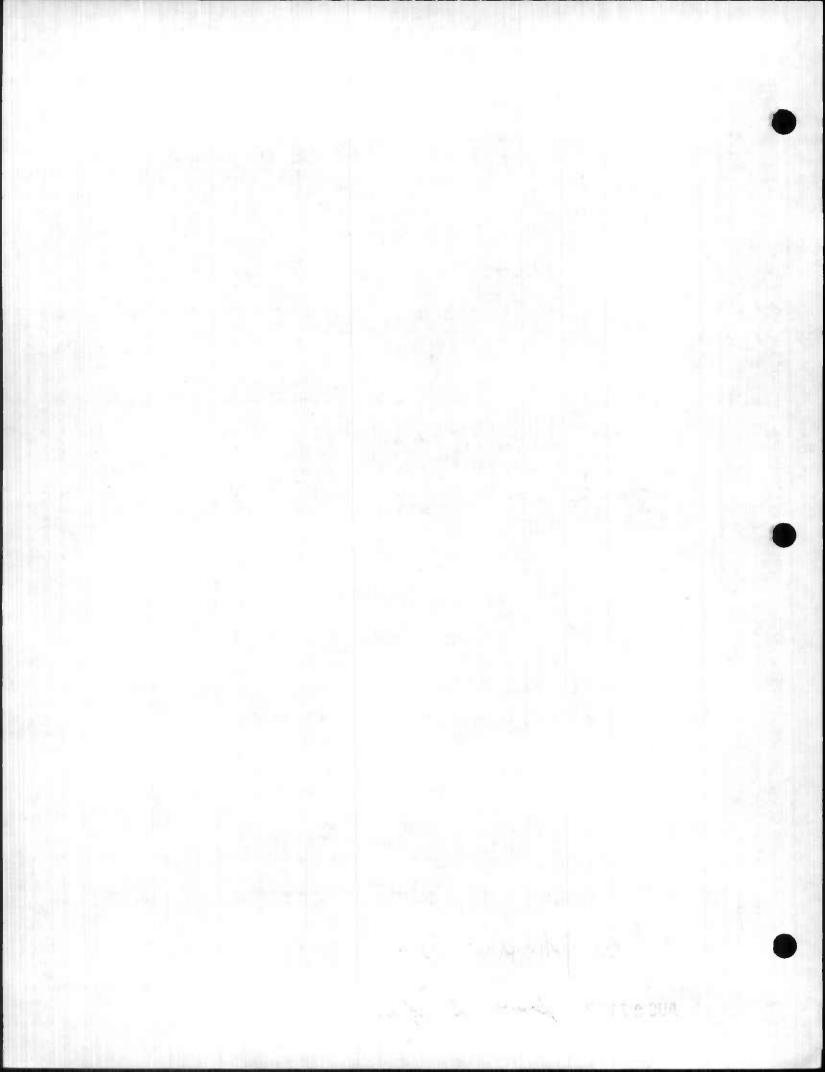
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32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Fredia Marie Justus 25 5:2090 August 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death 5. Social Security Number Kosedale HOSPITAL cente x1+ more H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
April 29,1919 If Under 1 Yeer 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Months Deys 1□M 2X F 80 217 10 5669 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Maryland Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 59 Sorgen Ct. 21220 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Bleck, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife 8 Own Home 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Robert Shaw Isabelle Unk. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Williams (Daughter) 3105 Putty Hill Ave. Baltimore, Md. 21234 20b. Pteca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State Md. Veterans Cemetery 8/30/1999 Garrison Forest, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funerei Service Linum 22. Name end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cause on each line. Approximate interval Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in death) Pulmonary Disease nd Stage Chronic Obsts Due to (or as e consequenca of): Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Gastrontestinal Bleed, Left Anterior Descending 24b. Were autopsy findings svailable prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yes No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

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after death Director: A

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altimore, Maryland 21215-0020

and Mental

Pages 1

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reportant: If Item 27 is marked

Tustus

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical

Colon Cancer

25. Was case referred to medical

1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 ☐ Accident Investigation

6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 FNOutpatient 3 DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Baltimore, MD. 21237

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

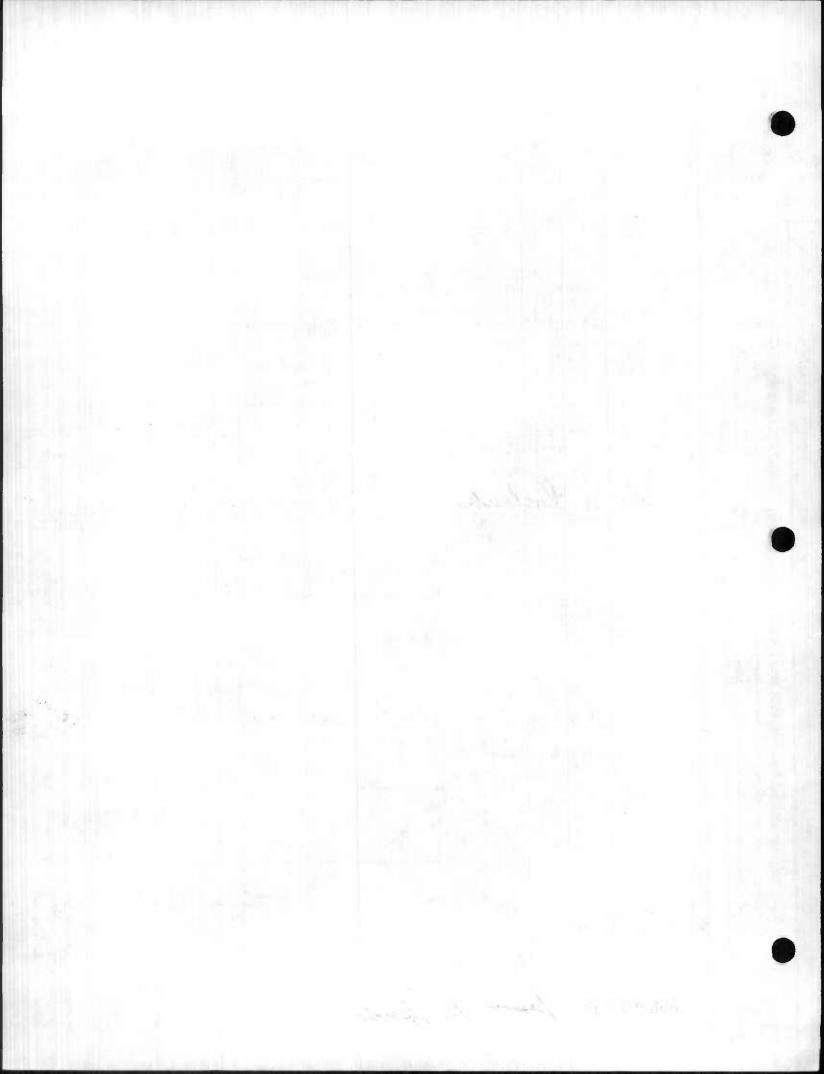
rson who completed cause of death (ttem 23a) (Type, Print) 9000

Rita Mathuc AUG 2 7 1999 State Registrar

29e. Certifier

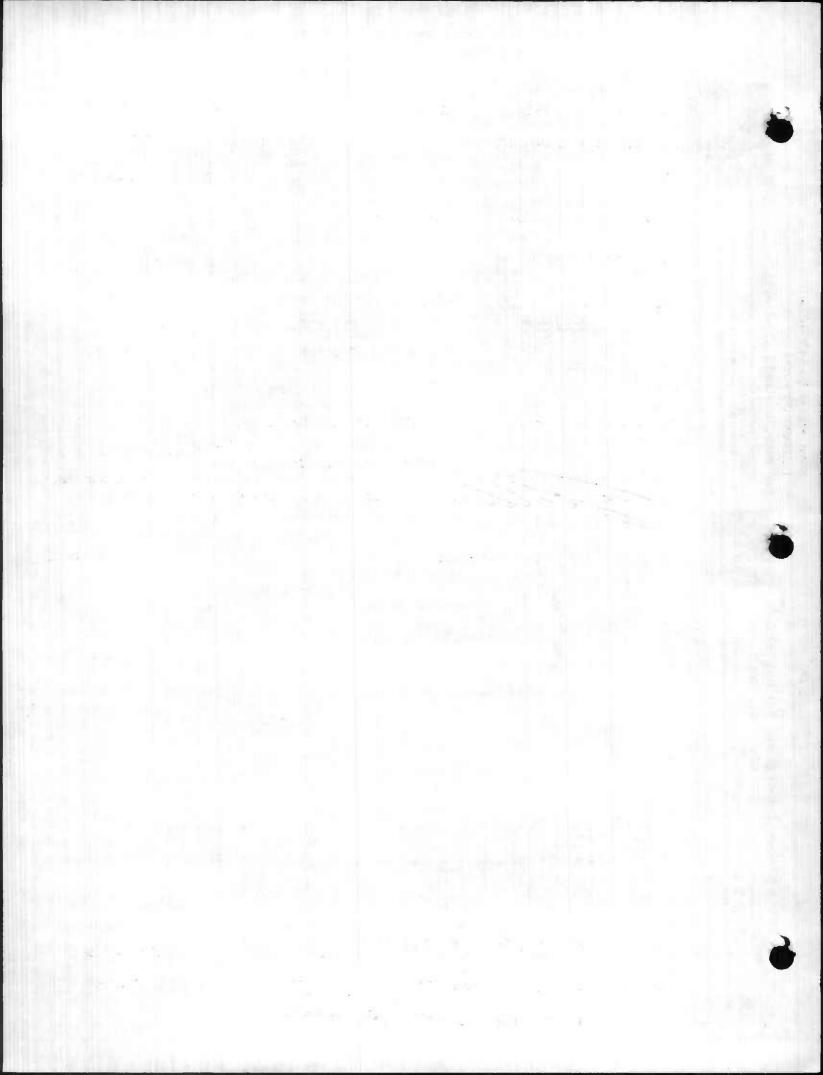
Franklin Square Diive 32. Registrer's Signeture

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Be Completed by Funeral Director	4a Facility Neme (If not institution, give VA MARYLAND HEALT. 5. Social Security Number 6. S 029-18-1716 Usuel Residence of Decedent 10a. Stete 10b. County MD Anne Aru 10e. Streef and Number 1420 Isterd Road 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Each (Specify only highest grave) Elementery/Secondery (0-12) 12. Tether's Neme (First, Middle, Last)	e street end number) H CARE SYS ex 7. Ag The street of th	STEM ge (In yrs. last bil 72 10c. City, Tow Glen Ever in U.S. No. 1945-68	rithday) If Under Months In or Location Burnie 10f. Zig 13. Wes Dece If Yes, spe	Code 2106	PERRY if Under 2 Hours	POINT 24 Hrs. 8. E Min.	Date of Birth Month, Dey -23-1	CE(7, Yeer) 927	9. Birthole Counti Massa	ny) Ichusetts Id. Inside City Limits 1□ Yes 2☑ No
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8	12 17. Fether's Neme (First, Middle, Last)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					U.S. A			
		12				Stair Sergeant					ıy
To	Gordon R. Johnson	17. Fether's Neme (First, Middle, Last)				18. Mother's Name					
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	20e. Method of Disposition		20b. Pleca o	of Disposition (Ne	me of		D	ete	20c. Location		
	1 Buriel 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify			and Vete				7/99 e	Crowns	ville,	MD
đ	21. Signature of Funerel Service Liber	1500				ess of Facility			n Funer	ral Ho	me P.A.
8	136	1		1 Seco	nd A	Ave. S	.W. G1	en Bu	rnie, 1	MD 210	61
	23a. Part 1 Emily and disease, or company feilure. List only	plications that ceuse one cause on each li	d the death. Do ine.	not enter the mod	de of dyi	ing, such es	cardiec or res	spiretory ar	rest,		Approximete Interval Between
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r	Immediate Cause (Final disease or condition resulting in deeth)	e PNEUM								3	WEEKS
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Physician/Med								001 0144			
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150 150	3 ☐ Suicide 6 ☐ Could not be	289. Place of in	28e. Place of Injury - At home, farm, street, factory, office					281. Location (Street and Number or Rural Route Num			
Cert	≈ □ nomicide building, etc. (Specify)						Ony or You	m, Steley			
dicai	29a. Certifier (Check only one) 13 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mennar as considered. 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as considered.										
Z	29b. Signeture and title of certifier	/		29	c. Licen	se number			29d. Date signe	ed (Month, E	Jay, Year)
- 1	Ca Ck	Ve	~ m	1) [1660	08			AUGUST	24, 1	999
	30. Neme and eddress of person who	completed cause of c	death (ftem 23a)	(Type, Print)							
		and the last		and the same of the same of				RY PC	DINT, MI	2190	2
	JI. Dete filed (Month, Day, Year)	7 1999	ars signature	1.			4				
	Medical Certification: To	25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Maturel 5 Pending investigation of Deeth 1 Maturel 2 Accident 1 Medical Example 2 Medical 2	25. Wes case referred to medical exeminer? 1	25. Wes case referred to medical exeminer? Wanner of Deeth Wa	25. Wes case referred to medical exeminer? 1 Yes 2 No	25. Wes case referred to medical exeminer? 1 Yes 2 No Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other 27. Manner of Deeth 1 Impatient 2 ER/Outpetient 3 DOA Other 28. Dete of Injury 28b. Time of Injury 28c. I	25. Wes case referred to medical exeminer? Yes 2 No	25. Wes case referred to medical exeminer? Ves 2 No	25. Wes case referred to medical exeminer? Ves 2 No	25. Wes case referred to medical exeminer? 1	25. Wes case referred to medical exeminer? Ves 2 No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Nama (First, Middla, Last) Month Day Elizabeth August 26, 1999 4:45am 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care at Canton Harbor Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1 ■ M 2 🖾 F Months 94 213-30-0278 10-17-1904 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits n/a Baltimore 1⊠ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 139 N. Janney 21224 Street USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6th Homemaker In own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen Helfer Lena (unknown) 19a. Informant's Neme/Relationship (Type, Print) Son 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Kress 139 N. Janney St., Baltimore, Md. 21224 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 8/30/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr., Funeral Home 21 Signtfline of Funeral Service Licenses 263 S. Conkling Street, Baltimore, Maryland 21224 anne 23a. Part. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in death) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? e on to pewix 1 Yes 2 No 3 Probably 4 Unknown osculo d'sens 24b. Were autopsy findings svaliable prior to 24a. Wes en autopsy performed? completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

that the death certificate be swocuted

P.O. Box 68760.

Records.

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

mast be notified at

Norma 23a

"natural", or

permit. Peges 1 and 2 ahould be filed within 72.1 Department of Heelth and Mental hyglene. Important: if item 27 is marked other than "nat, any injury or other traumatic event, the Medical price.

Director

h

Completed

MD

the Maryland

death

72 hours after

Baltimore, Maryland 21215-0020

physicien and the burial-transit bengis certificata death. To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

Examiner Physician/Medical by Completed Be Medical Certification: To 27. Manner of Death

25. Was case referred to medical examiner?

1 Yes

1 DNaturat

3 Suicide

29a. Certifier

4 Homicide

2 Accident

A DAY

29b. Signature)and title of certifier

5 Pending

investigetion

6 ☐ Could not be

Registrar DHMH 16 Rev 6/95

State

to AUG 2 7 1999

dico gos

Hospitel:

28a. Date of Injury (Month, Day Year)

PATRICIO 32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

**Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

1 TYes 2 No

S. CLIMTOM ST

26. Piace of Death (Check only one)

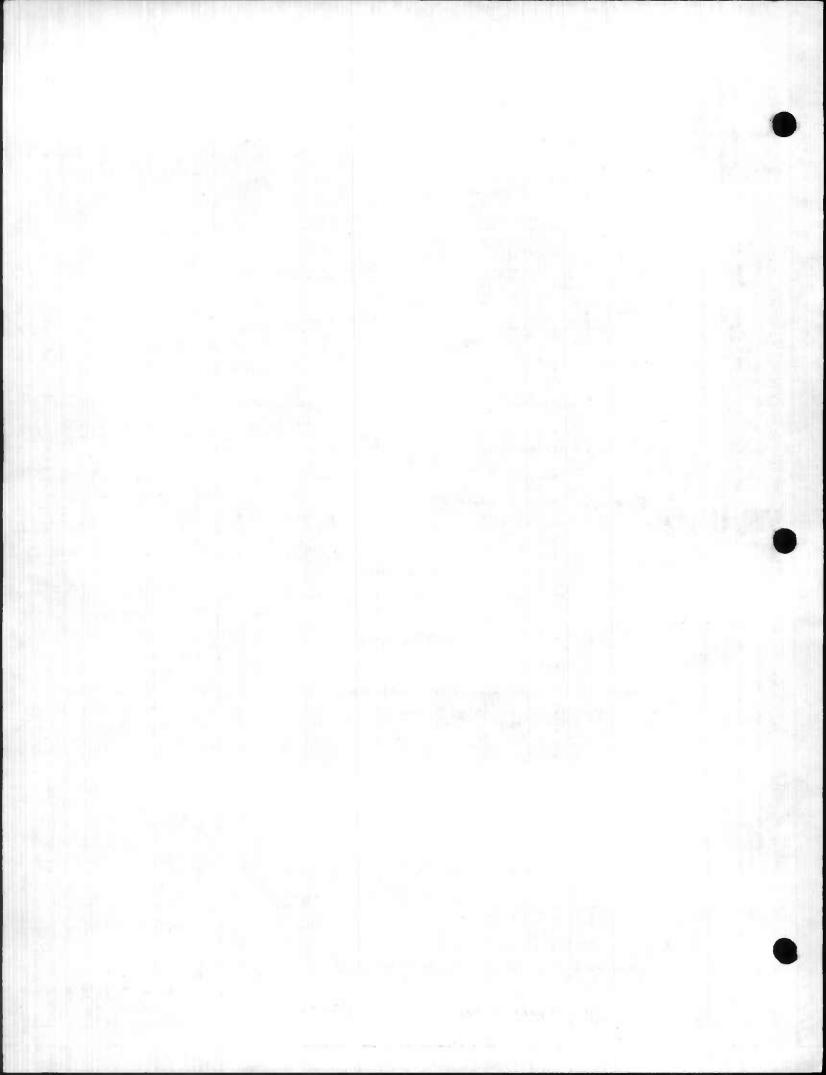
Other: 4D Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

1 1010 RE

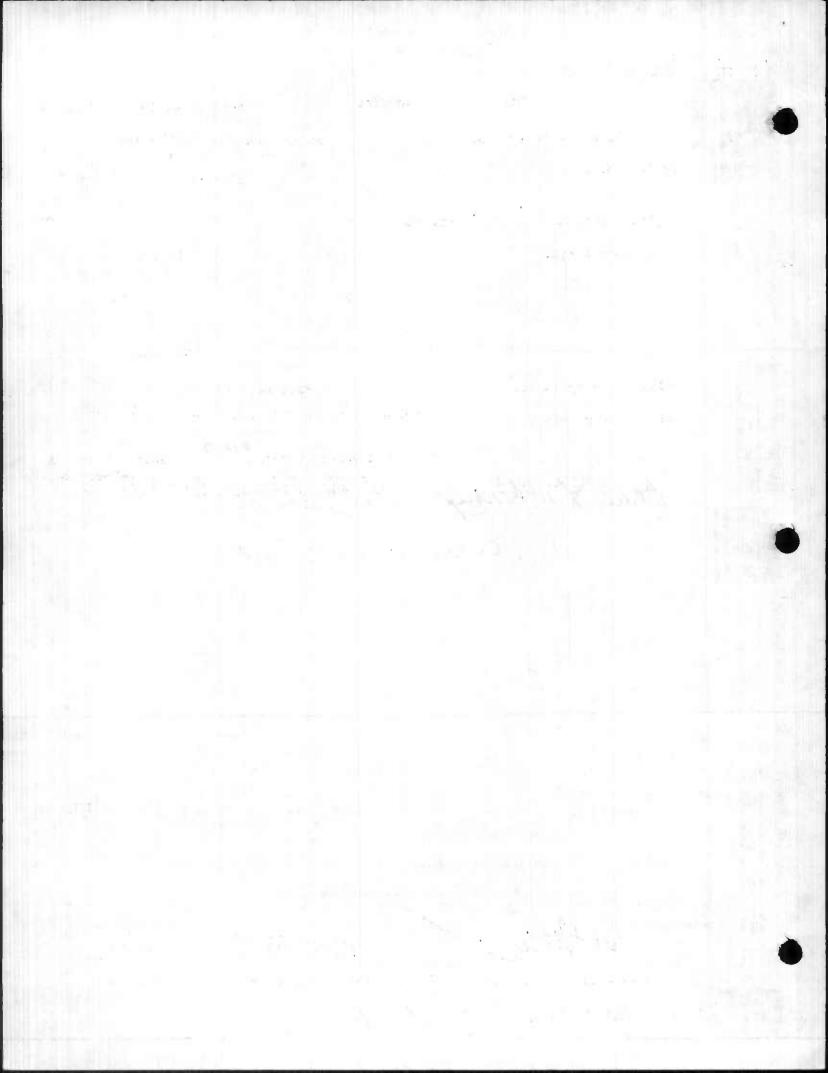
281. Location (Street and Number or Rural Route Number, City or Town, Stete)



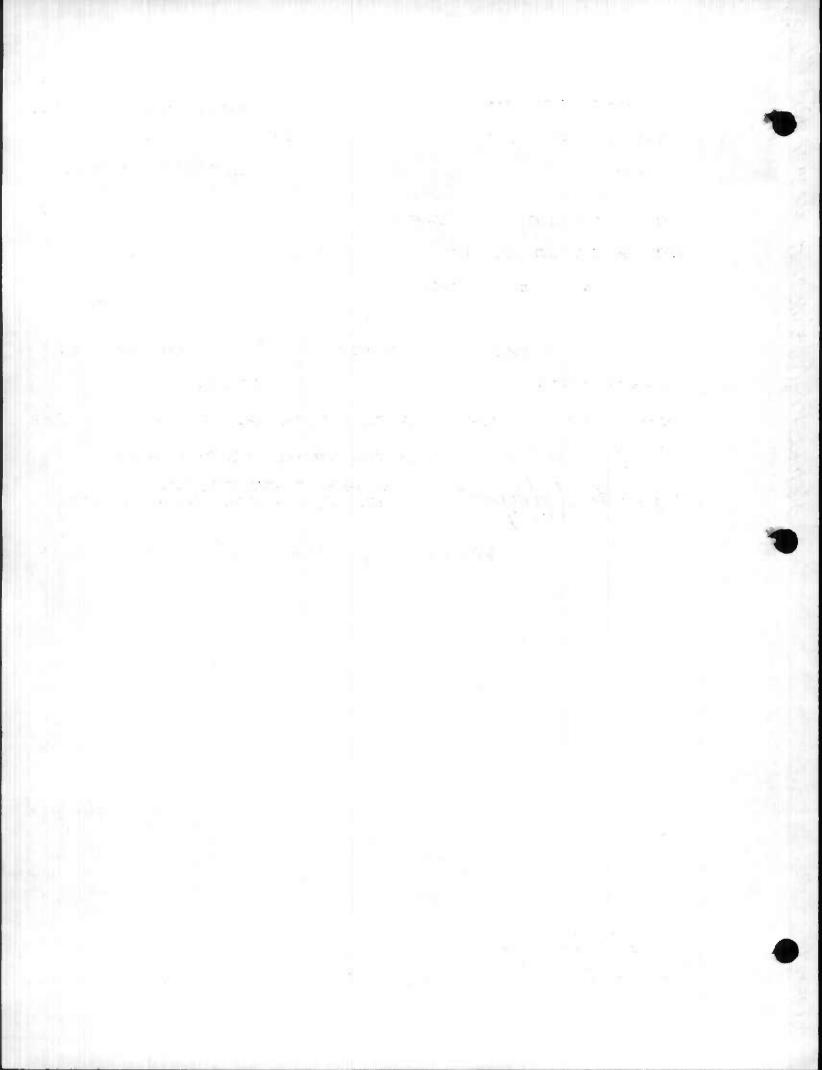
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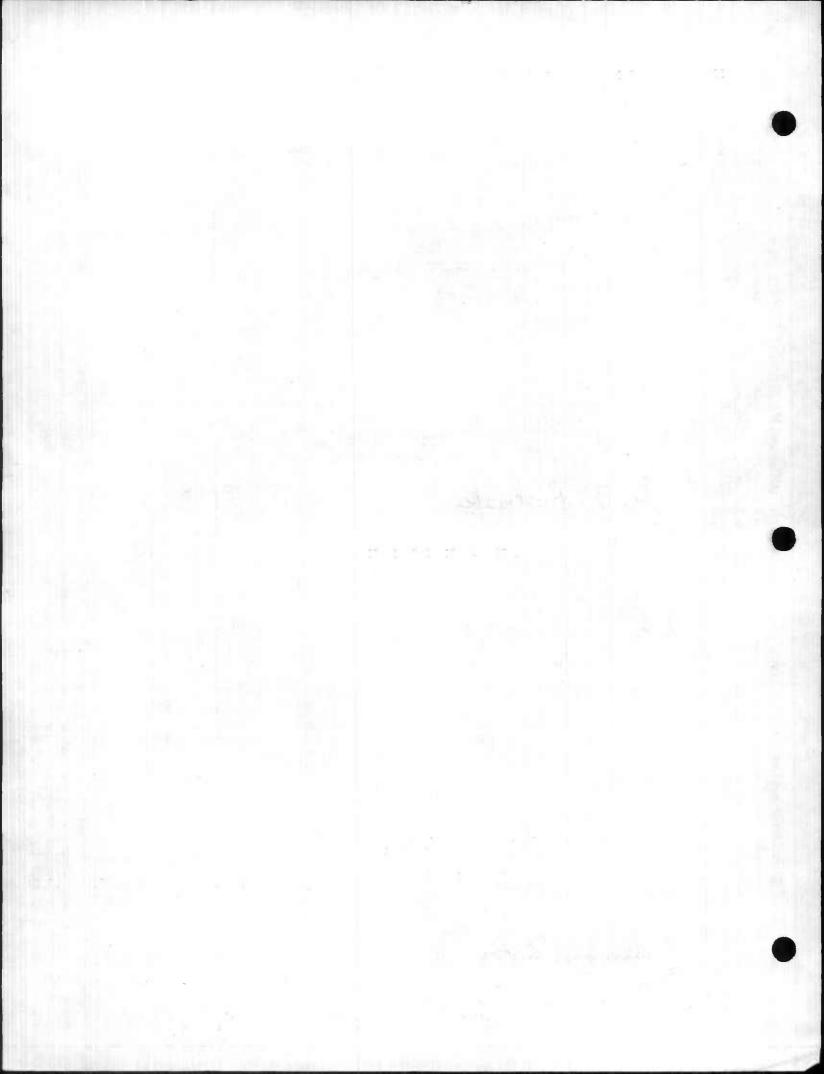
State of Maryland / Department of Health and Mental Hygiene

	15	1. Decedent's Name (First, Middle	7-99 WR.		00	ertificate of	Death			eg. No.	99	20310
ysici Medio		Clara		Otis		ndler			2. Dete of Deet Month August	Day	1999	3. Time of Death 7:00 AM
amir		4e. Fecility Neme (If not Institution 17116 Magruder										h
eral ector		577-18-4782 A	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs	5. last birthday, 5 Yrs.	Months Dey	r If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Dey, Aug. 11,	Year)	9. Birt Co V 1	hplece (State or Foreig untry) rginia
important; it item 2.1 is marked other than "netural, or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating must be notified at once."	tor	Usual Residence of Decedent 10e. State 10b. County Virginia Fauqu	ier		City, Town or Li	ocation						10d. Inside City Limit
	Direc	10e. Street and Number		10f. Zip Code				10g. Citizen of Whet Co			untry?	
	by Funeral Director	8223 Rogues R 11. Marital Stetus 1 Never Married 2 Marrie 3 Widowed 4 Divorcad	12. Was De Armed F ed 1 Tyes If Yes, G	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		r in U,S. 13. Was Decedent of His if Yes, specify Cuben. 1 □ Yes 2√2 No		gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	U.S.A. 14. Raca - American India Bleck, White, etc. Specify: white		e, etc.
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er traume		19a. informant's Name/Relationsh Lorraine Brown-s	ilp (Type, Print)		19b. Maili 670	ing Address (Stree Bella Vi	et end Numbe	r or Rurei	Route Number,	City or To	own, Stete, Z	(ip Code) 32780
ury or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremetion 4 □ Donation 5 □ Other (Sp		20b. Place of Disposition (Neme of cemetery, cremetory or other place) Hillcrest memory Garden				dens	8.18.99	Je		onton VA
OUCE.		21. Signature of Funeral Service CHARLES	SELANG	ER DI M O	2: N	2 Name and Add LEE FUNER Oser Fur	less preacility neral H	INC.	6633 OLD Inc. 23	ALEXA 3 Bro	NDRIAW advie	arrenton-V w Ave,
		23a. Part1. Enter the diseese, or of shock, or heart feilure. List of	complications that only one cause on	caused the des	F	PERRY ROAD ter the mode of dy	CLINTO	N. MD	20735			Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth **Physician** Month Year CASIMER FELIX KOTOWSKI 25, 1999 AUGUST 7:25 P.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** GILCREST HOSPICE CENTER TOWSON BALTIMORE 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 11/20/19 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign Funeral Days Hours KIM 2 F MARYLAND Director 200-09-8507 Yrs 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 28a-f MD BALTIMORE GLENDALE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6920 DONACHIE ROAD APT. 1102 21239 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedenl of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, alc. Y Yes 2 No WWII If Yes, Giva Yaar or Dates: 1 ☐ Never Married 2 [X Married 1 ☐ Yes 2 ☐No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 콥 4 YEARS ACCOUNTANT STATE OF MARYLAND 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be BOLESLAV KOTOWSKI ANNA PODLESANA 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) WIFE MARIE KOTOWSKI 6920 DONACHIE ROAD APT. 1102 GLENDALE, MD 21239 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8/30/99 LORRAINE PARK CEMETERY 4 Donation 5 Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. hion, that caused the death. Do not enter the mode of the death on each line. 21286 ock, or heart feilure. List only Approximate Interval Betwaen Onset and Death **Physician** ladder Concer Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequença of) 68760 certificate be Physician/Medical that Initieted events resulting in death) Last Due to (or as a consequence of) Box Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 23b. Did tobacco use contribute to the cause of death? ۵. 1Yes 2□ No 3 Probably 4 □ Unknown Records, by 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24e. Was an autopsy performed? The law 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Attending 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter deatl 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 24 hours e 29a. Certifier Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and tilla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 25205 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) N. Charles St. 6-BMC 6701 160 104 31. Dete filed (Month, 32. Registrer's Signature State AUG 2 Registrar **DHMH 16 Rev 6/95**





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** EE EBORAH VIC TORIA 16am UGUST /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN BALTIMORE
| HUnder 24 Hrs. 8. Data HOSPITAL If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛱 F Director 218-58-6755 Maryland with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itama 23a or 28a-f ahow traumatic avant, the Medical Examinar must be notified at Maryland 1 Yas 2 □ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3923 Rexmere Road 21218 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 210 No If Yes, Give * Year or Dates: 14. Raca - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. al Hygiene. I other than "netural", or itel 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Itam 27 Ia marked other any Injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Surname) Be Melvin Rogers Lee Roberta Geneva Milbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Barr / Sister 3529 Old York Road, Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/31/99 Baltimore, Maryland King Memorial Park, Inc. 22. Name and Address of Facility The Derrick C. Jones Funeral Hm., 21. Signature of Funaral Sarvice License 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Monan Examiner Due to (or as a consequence of): Examiner sician and burial-transit MAY certificata be axacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760 meline Due to (or as a consequence of): Physician/Medical Obesil USB (to P.O. been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the unitaritying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 Yes 20 No Division of Vital 25. Was case referred to medicat examiner? Be 26. Placa of Death (Check only one) To Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: After Attending 1 [/Watural 5 Pending investigation il or Attanding s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ HomicIde Hospital of To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature 29c. License number

Registrar **DHMH 16 Bev 6/95**

State

31. Date filed (Month, Day, Year)

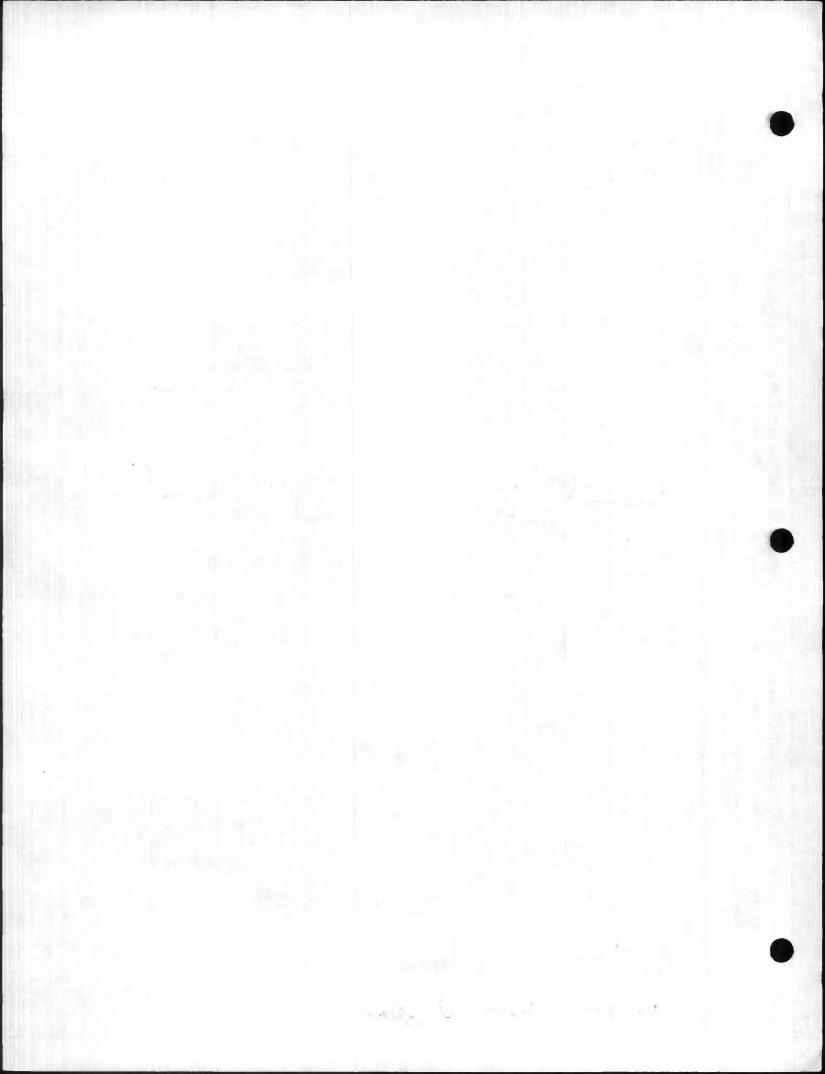
AUG 27 1999

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completed cause of death (Item 23a) (Type, Print) 561

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Dev Month Veer Martha Wickes McKeever 24 1999 AUGUST 04:15 AM 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs BALTIMORE If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 1□M 2QF Hours 095-34-1628 66 Aug. 5 1933 Canada Usual Residence of Deced 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 XNo MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11 Stillway Garth 21030 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 K No 1 Never Married 2[30Married White 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18 Mother's Neme /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) Stanley Boyd Wickes Winefred Sandilands 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Stillway Garth, Cockeysville, MD 21030 Robert W. McKeever/husband 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a, Method of Disposition 8/27/99 Burial 2 ☐ Cremation 3 ☐ Removal from State **Dulaney Valley Memorial Gardens** Domer (Specify) Timonium, MD e oter 22. Neme end Address of Fecility veral Service M Melemmon Lemmon Funeral Home 23a. Part. Edia: the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately and the deeth of the shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth on Distress Syndrome Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Ves 20 No 3 Probably 4 Unknown neumonecton 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) TO Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural

Examine Box 68760 Records, P.O. Division of Vital Attending death.

Completed Be

Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

by

Funeral

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permit. Pages 1 and Department of Health a Important: If Item 27 is any Injury or other P

Physician

/Medical

Examiner

Maryland 21215-0020

Baltimore,

REEVER,

þ

or Attend after death Director: To the Hospital or within 24 hours att To the Funeral Dit completely filled in Medical

> State Registrar

31. Date filed (Month, Dey, Year) AUG 2

2 Accident

3 Suicide

4 Homicide

(Check only one)

29e. Certifier

investigation

6 Could not be

29c. License number P000 6189

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

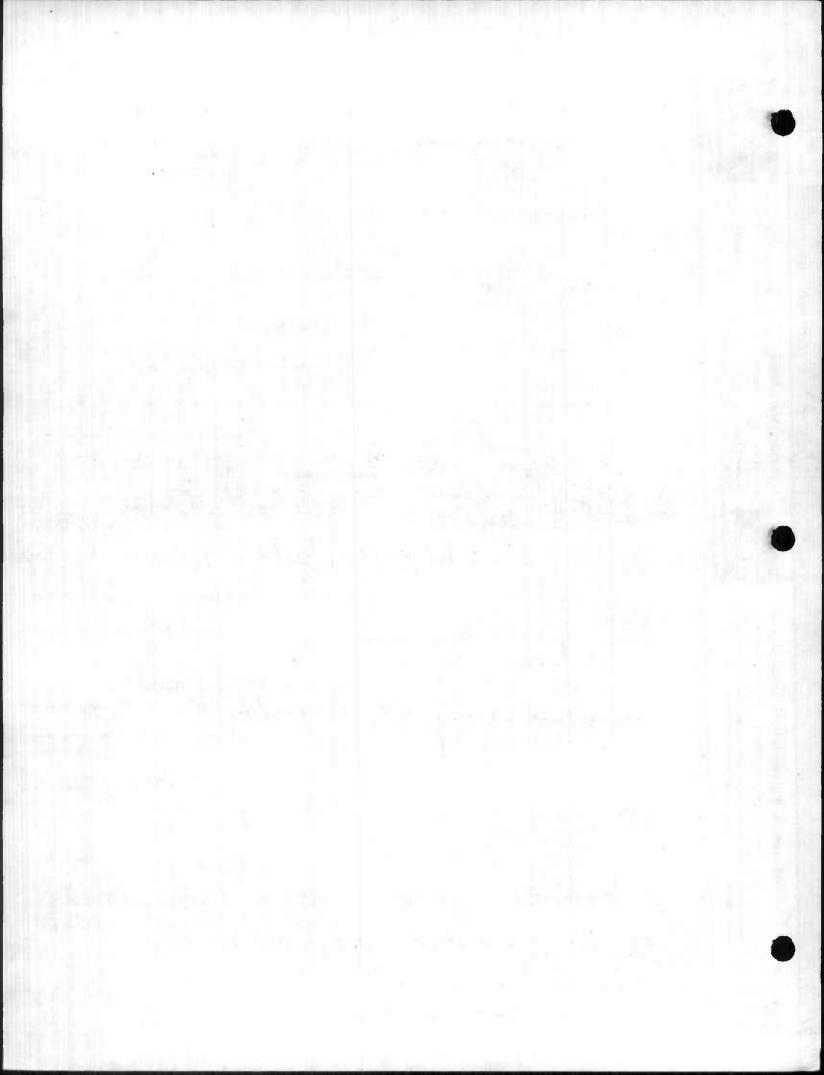
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #22 LUTHERVILLE MD21093

32. Registrer's Signeture parks

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibles State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND: #23 PART I, PER G774 8-27-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Year MELVIN FOSTER 9.25 pm AUGUST 1999 /Medical Π 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL GOOD SAMARITAN BALTIMORE BALTIMORE 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month) Dey, 9. Birthplace (State or Foreign Country) **Funeral** Hours 10 M 2□ F Months Days 245-18-4946 Yrs. Director Usuel Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show 1 Yes 2 No MO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 21212 Spring La 12. Was Decedent Ever In U.S. Armed Forces? Funeral 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed withIn 72 hours efter 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: The Madical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. SIA 17. Father's Name (First, Middle, Last) Be Peges 1 end 2 should be f nent of Health end Mental I int: if Nem 27 Is marked of 40 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) KOSA MEIVIN 508 E. Baltimore Cold Sting item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of competery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Department of Important: If any Injury or ¥ ŏ 4 ☐ Donetion 5 ☐ Other (Specify) butus 21. Signature of Funeral Service Licensee 22. Name end Address of Facility CALOLINE 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** ATRIAL FIBRAILLATION /Medical Immediate Ceuse (Final MADEN CARBO diseese or condition resulting in death) MINTES Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significent conditions contributing to death but not resulting In the underlying cause given in Part I. P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? Completed ATRIAL FIBRILLATION this certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 17 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! 1 Natural 2 Accident 5 Pending in 24 hours efter deeth. Ne Funeral Director: After pletely filled in by the fun Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) P12557 AUGUST

State Registrar

AUG 27 1999

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31. Date filed (Month, Dey, Year)

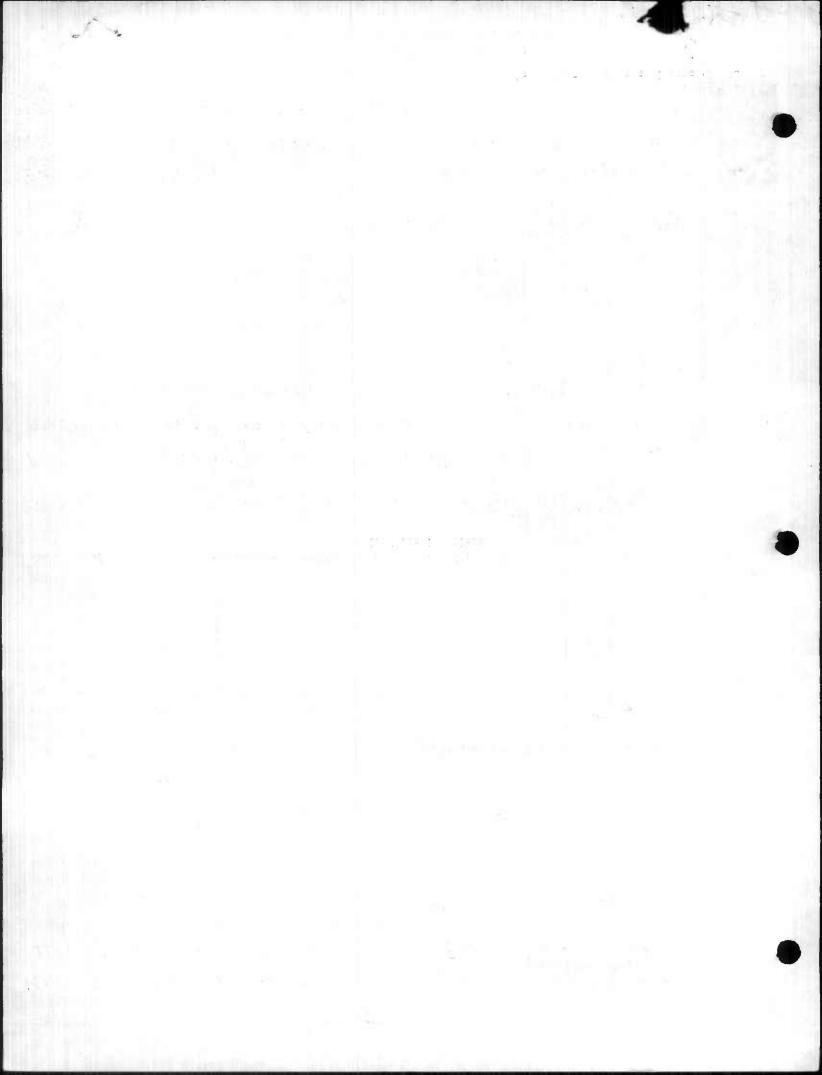
32. Registrar's Signature

DODOO, 5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

b. Spals

LOCH RAVEN BWD BAITIMORE

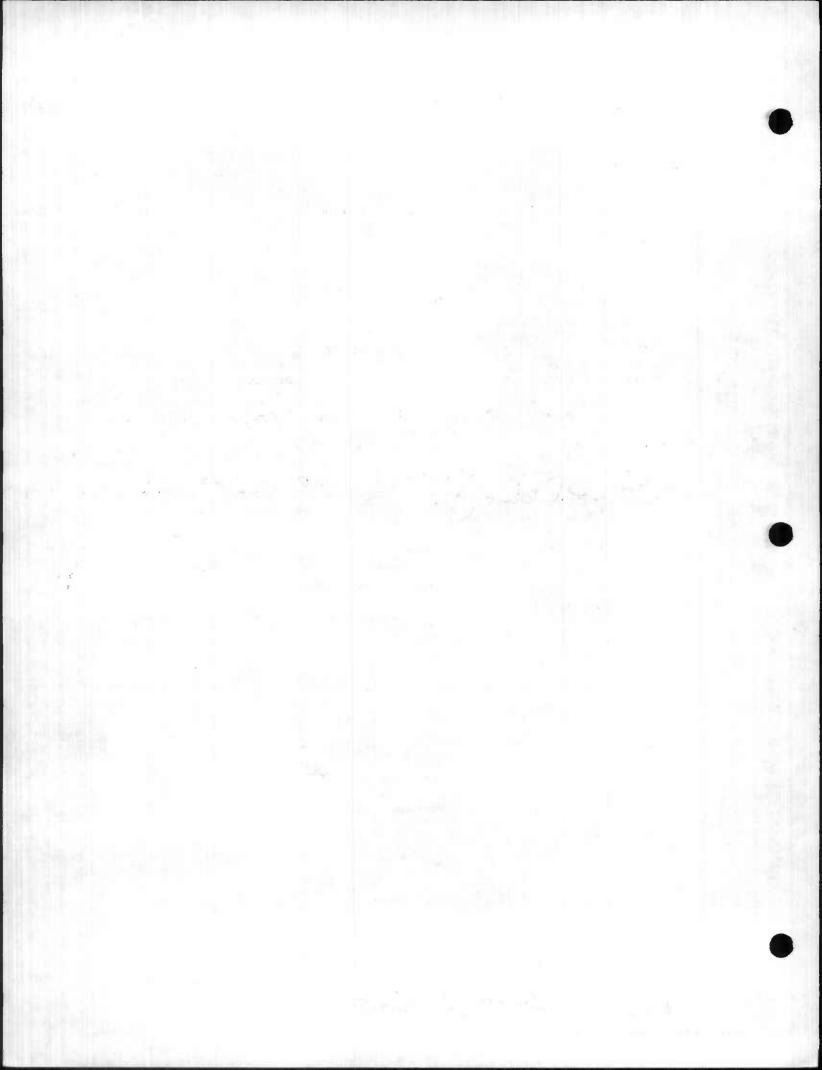


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			Maryland		cate of l	ealth and I Death		Reg. No.	9 2	6976
Physician /Medical	1. Decedent's Name (First, Middle RICHARD	CHARD GILMORE MARTIN						Dey 23	Yeer 1999	3. Time of Death 10:30 Af
Examiner	4e Facility Name (If not institution HARBOR HOS	-			1		ity, Town, or Location of Death 4c. County ol Death N/A			
Funeral Director	5. Social Security Number 217-09-9142		7. Age (In yrs. Ia 78		Under 1 Year onths Deys	If Under 24 Hrs. Hours Min.	-	th y, Year)		ce (State or Foreig y) VA
	Usual Residence of Decedent 10a. Stete 10b. County		10c City	Town or Locatio	0				110	d. Inside City Limit
Had at find at tor		Anne-Arundel Pasadena Maryland								1 ☐ Yes XXN
the or 28a-fa at he notifies al Director	10e. Street and Number 137 Club Road		10f. Zip Code 21122			10g. Citizen of What Country? United State				
al', or literus 23a Examiner must by Funeral	11. Merital Stetus 1 Never Merried 2 Merri CWidowed 4 Divorced	Armed For	2 No Nav	y II Yes	Decedent of H , specify Cuba ∕es 2,⊡{No	ispanic Origin? (S) n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		ck, White, et	ic.
ygiens. Not the Medical. Completed		15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)			Usuel Occupa of work done of OT use retired	furing most of wor	king	16b. Kind of B		
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nt: if leen ry or othe	20a. Method of Disposition 1 Durial 2 Cremelion 4 Donetion 5 Other (Sp		tete Cer	ace of Disposition metery, cremator ar Hill	y or other plac		Dete 27,199	20c. Location		m, Stete Maryland
Departm importa any inju	21. Signeture of Funeral Service I	icensee Victor	P. Doda,	Chai	me end Addres cles L. L East	Stevens	Funera	l Home,	Inc.	and 2123
physician and street st	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b. UNR	Due to (or or	es e consequence LE No es e consequence DBSTRU es e consequence	ON SMA e of): CTIVE e of):	PULM			Se	5 DAYS
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been signed by the attending t should be detached for use as leted by Physician/Me			ributing to death but not resulting in the underlying cause given in Pert I.							the cause of deati
2 should	RADIATION	ESOPHA	GITIS				24a. Wes	an autopsy rmed?	evai	e autopsy findings leble prior to apletion of cause eath?
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octor: After this certific by the funeral director, ffication: To Be	1 Yes 2 No 27. Menner of Death 1 Meturel 5 Pending 2 Accident Investigation	28a. Dete of (Month	28a. Dete of Injury (Month, Day Year) 28b. Time of Injury			4 □ Nursing H / at /? Yes 2 □ No	lome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
er in	3 ☐ Suicide 6 ☐ Could n 4 ☐ Hornicide determi	ned 288. PIBCB 0	0 00 00 00 00					281. Location (Street and Number or Rural Route Number, City or Town, State)		
within 24 hours To the Funeral completely files Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bearings: On the bas	sis of examinetic	edge, deeth occ on and/or investig	urred et the tim jetion, in my of	ne, date and place pinion, deeth occu	, and due to the rred at the time,	cause(s) and modate and place,	enner as sta and due to t	ited. the cause(s)
To the comp	29b. Signeture and fitle of certifier				29c. License	number		29d. Date signe		
R	30. Neme and address of person v		2N PG-			5000	/	LUGUST	23,	1999
,00	TSHERING DOF	JEE Ambo	, HARB	or Host		ENTER,	3001 Sa	TH HANOL	IGR STI	REET, BALTI
State Registrar	AUG 2 7 1999	Sen 32. Re	gistrer's Signatu	Sport	N					

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 607 1. Decedent's Name (First, Middla, Last) 2. Data of Death Dev Month Year JOAN DALY MURPHY August 4b. City, Town, or Location of Death 27, 1999 2:53 A.M 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth 3521 Newland Road Baltimore City N/A 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) If Undar 1 Yeer Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Davs 1□ M 21 F 212-26-1314 May 2, 1928 Maryland Usual Rasidence of Decedent 10a State 10b. County 10c. City Town or Location 10d. Inside City Limits Maryland N/A 1 Yas 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3521 Newland Road 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Bleck, White, atc. 1 ☐ Yas 2 ☑ No If Yas, Give △ Yaar or Datas: 1 ☐ Never Merriad 2 ☑ Married 1 Yas 2♥ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Telemarketing Agency 12th Corporate Executive 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First Middle Last) Eugene Dalv Lee Marie Garrity 19e. Informent's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edward Hanlon Murphy, Sr 3521 Newland Road, Baltimore, Maryland 21218 20b. Place of Disposition (Name of commetary, cramatory or other place) Baltimore, Maryland 21218 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/28/99 Baltimore, Maryland Green Mount Crematory 21. Signeture of Funeral Sarvice 22. Nama and Addrass of Facility Martin Lawson Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore Maryland 21212 23a. Part1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as Cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Intarvai Batween Onsat and Death Immediate Cause (Final Month & disaasa or condition rasulting in death) vunoma Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last artinoma Dua to (or es e consequance of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas ANNO 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

Pages 1 and 2 should be filed vent of Health and Mentel Hygient: If them 27 is marked other t

permit. Page Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Director

Funeral

A

Completed

Be

sician and buriel-transit physician a Certification: To funeral

Physician/Medical been signed by the a should be detached þ Completed certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be

1 Natural

2 Accident

3 Suicide

29a. Certifiar

4 Homicide

(Check only one)

29b. Signatura and title of certifian

Registrar

DHMH 16 Rev 6/95

completely

within 2 To the

State

Medical

31. Data filed (Month, Day, Year) AUG 27 1999

5 Pending

investigation

6 Could not be datarmined

30. Nema and addrass of parson who completed causa of death (Item 23a) (Type, Print)

32. Registrer's Signature

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

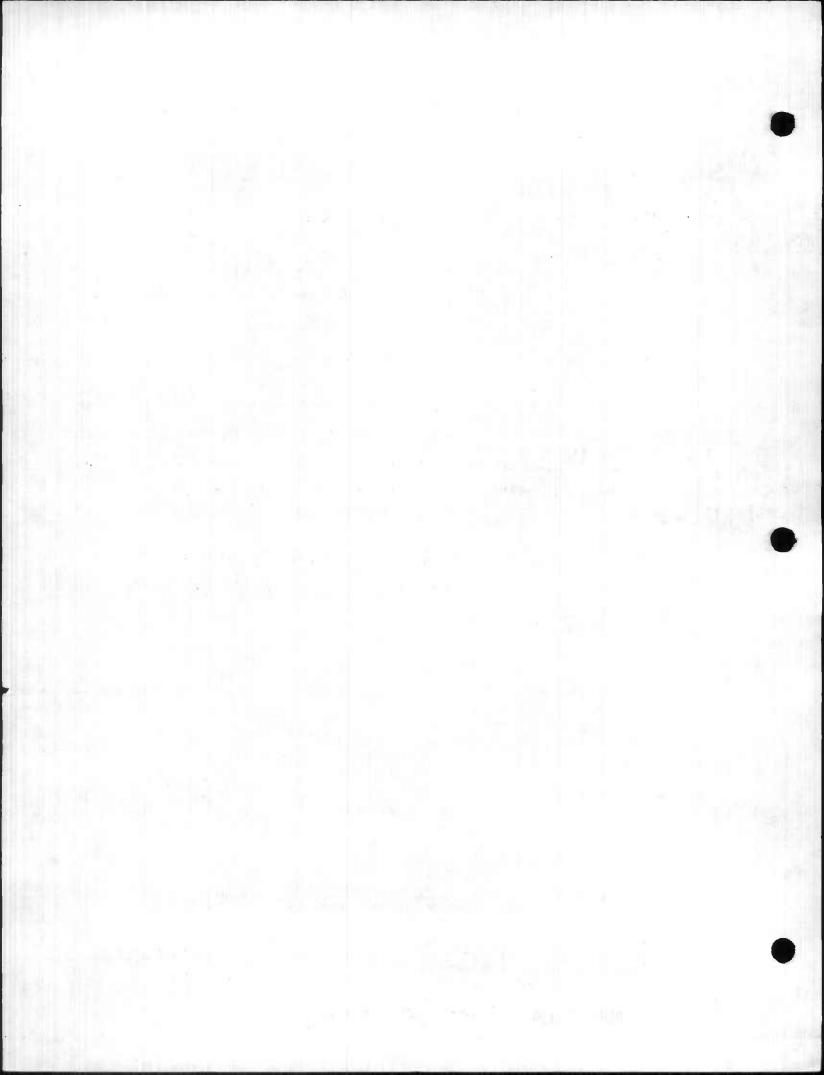
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

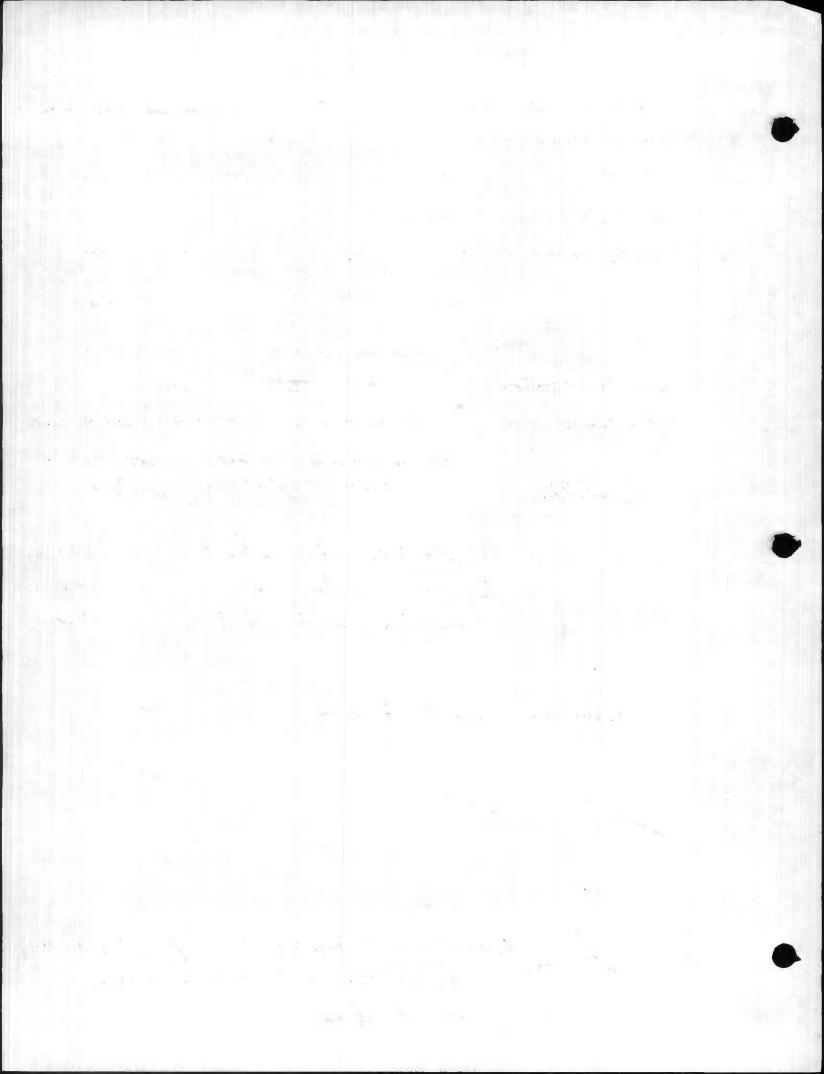
29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 26 1999 Donald George McClure, Sr. 4b. City, Town, or Location of Death 1525 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year 5. Social Security Number 6. Sex 1 M M 2 □ F if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dale of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Montha Davs Hours Min 215-12-7398 82 Yrs. August 12 1917 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Manyland rent of Health end Mentel Hygiene.

nt: If tem 27 is marked other than "naturel", or items 23s or 28s-f ahow 10a State th and Montel Hygiene.
7 is marked other than "naturel", or itema 23a or 28a-f ahow traumatic event, the Wedical Evanther must be notified at 10h Count 10c. City. Town or Location 10d. inside City Limits 1 X Yes 2 □ No Baltimore Maryland N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Ridgemede Road Unit 201 21210 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yas, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Ves 2 No Specify: Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Financial Executive Retail Service 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Name (First, Middle, Last) Clayton Edward McClure Marie Shipper 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Irma V. McClure (Wife) 310 Ridgemede Road Unit 201 Baltimore, MD 21210 or other 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If I any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 8/30/99 Timonium, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service Licansee Steven 1. Eittle 6500 York Road Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final Examiner Examiner thet the deeth certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien ar Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not rasulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ law requires 24b. Were autopsy findings available prior to complation of ceuse of daath? 24a. Was an autopsy performed? Completed After this certificate has funeral director, page 2 1 Yes 2 No 1 ☐ Yea 2 ☐ No al or Attanding Physician: T s after death. I Director: After this certificat ed in by the funeral director, p 25. Was cese referred to median examiner? Be 26. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Marman Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturai 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b 1 Certifying Physician: To tha bast of my knowledga, daath occurred at the time, date and place, and due to tha causa(s) and mannar es stated. Medical 29a Certifian (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number 30. Name and address of person who ampleted ceusa of daath (Item 23a) (Type, Print) vescher 201 E. University 31. Data filad (Month, Dey, Year) 32. Registrar's Signature State Registrar **AUG 27**

AHI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

ın	1. Decedant's Nama (First, Middla, Last)			MATI	ONEE	2. Data of Death Month	Day Y	3. Time of Death	
1 -	HELEN HATTIE			MALL			22, 1999		
r 4	a Facility Nama (If not institution, git 8165 BODKIN AVEN	The second second		4b. City, Town, or L PASADENA		4c. County of ANNE AR			
	213-20-0509	Sax 7. Aga 1 □ M 2 🔀 F	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV. 22		Birthplaca (Stata or Foraign Country) LLINOIS	
1-	Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location							10d. Insida City Limits	
	MARYLAND ANNE	ARUNDEL	MILLERSVI	LLE	1 □ Yas ZÇ N				
	0e. Street and Number			10f. Zip Code		10	10g. Citizan of What Country?		
L	1241 INDIAN LAND			211			U.S.A.		
5	Narital Status Nevar Married 2 Married XWidowed 4 □ Divorced	12. Was Decedant B Armed Forcas? 1 ☐ Yas 2430 If Yas, Giva Yaar or Datas:	o 13. V	Was Dacedant of F f Yas, specify Cub	Hispanic Origin? (Span, Maxican, Puarti Specify:	Rican, atc.)		American Indian, White, atc. WHITE	
	15. Decedant's E (Specify only highest gr Elamantery/Secondary (0-12)	+)	lant's Usual Occup kind of work dona DO NOT use retire	pation during most of work d)	king	16b. Kind of Business/Industry OWN HOME			
1	7. Fathar's Nama (First, Middla, Last	1)	1101121	22.22.20.0	18. Mothar's Nan	na (First, Middla, M			
		ILLIAM	MENTI	ECKI	HATTIE	M	AGDALEN:	E CHRISTOPHE	
1	19a. Informant's Name/Ralationship				and Number or Ru				
-	MRS. LORRAINE MA	LLONEE			AVENUE, P			ID 21122 ty or Town, Stata	
2	0a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 [20b. Place of Dispo cematary, cran						
-	4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		OUR LADY					ILLE, MD.	
1	Signature of Turiara Sarvice Lica	0 / /						HOME, P.A.,	
-	23a, Part1, Enter the disease, or con	nolications that gaused						E, MD. 21061	
	 Part 1. Entar the disease, or conshock, or heart failure. List only 	ona causa on aach lin	a	A ()	1	0	-17	Interval Between Onsat and Daath	
1	mmediata Causa (Final	Met	atate	Ahd	Minul	Cance		3 years	
1	asulting in death)	8.	Dua to (or as a consec	uange of):	0				
S ill co		Coro	vary A	rtery	DIS	ease		5 years	
200	sequentially list conditions, any, leading to immediate		Due to (or as a conseq	uence of):					
00	Sequantially list conditions, fany, laading to immediate cause. Enter Underlying cause (Disease or injury hat initiated avants	C	Due to for on a con	uence off:					
	asulting in daath) Last		Dua to (or es a consaq	uanua OIJ.					
		d							
P	Pert II. Other significant conditions	contributing to death bu	it not resulting in the u	nderfylng causa gi	van in Part I.	23b. Did tol		ibute to the cause of death? Probably 4 Unknown	
(-						24a. Was an		24b. Wara autopsy findings available prior to complation of causa	
-						perform		of death?	
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2	25. Was casa rafarred to madical axeminar?							of death? 1 □ Yas 2₽No	
	axeminar? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		I 3LI DOA	har: 4□ Nursing H	1 ☐ Ya th (Check only one oma 5 ☐ heside	nce 8 🖾 Other	of death? 1 Yas 22 No Daughters (Specify) Residence	
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State Registrar

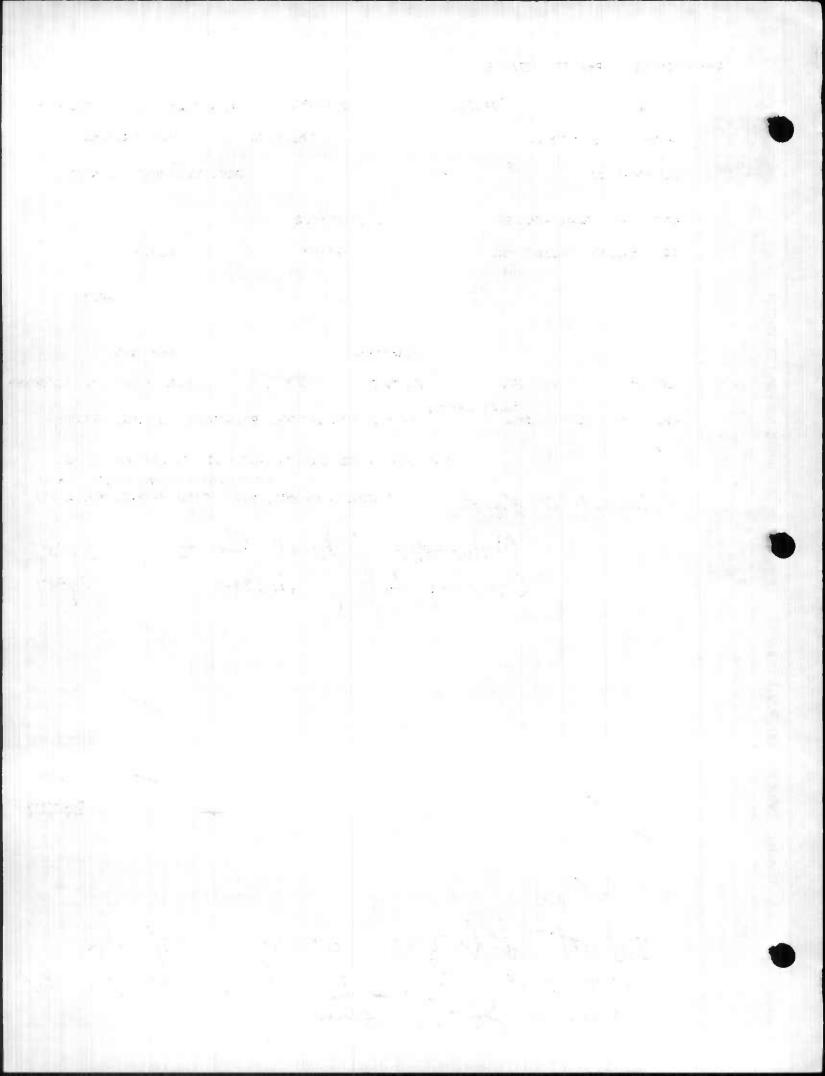
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32. Flogistrar's Signature B. Sports

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Please Type or Print In Black Indeilble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5986 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AUGUST 26 5.45 Am Marie Louise McCarthy /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Deeth Examiner BURNIE ANNE BRUNDRI NORTH ARUNDEL Glery HIRPITH If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M XXF Yrs. 075 03 5434 85 Oct. 19, 1913 Trenton NJ Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits hama 23a or 23a-f show her must be notified at 1 ☐ Yes Por No Directo Maryland Anne Arundel Gambrills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2261 September Drive 21054 United States Funeral 14. Race - American Indien, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Merried 2 Merried the Medical Examination 1 Yes 2√ No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Procurer 12 NASA 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) 8 Sherman Jones Marie E. Patrick Department of Health and Important: If Item 27 is may injury or other. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2261 September Drive Gambrills Maryland 21054 Patricia A. Jacobs Duaghter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 28, Date 1999 cemetery, crematory or other place) Aug. Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring Maryland 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 21. Signature of Funerel Service Licen 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the diseasa, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause of each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical EXHUERBATION OF CARONIC OBSTRUCTIVE LUNG DISEASE Examiner Due to (or es s consequence of): burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Last and Due to (or es a consequence of): physician s the burial Box 68760 Physician/Medical Dua to (or as a consequence of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Yss 2 No 3 Probably 4 Tunknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? peed page 2 1 Yes 2 No 1 Yes 20 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical Be 25. Wes case refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Menner of Death 28s. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and titla of certifiar Desch

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State

Registrar

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31. Date filed (Month, Day, Year)

AUG 27 1999

DRIVE

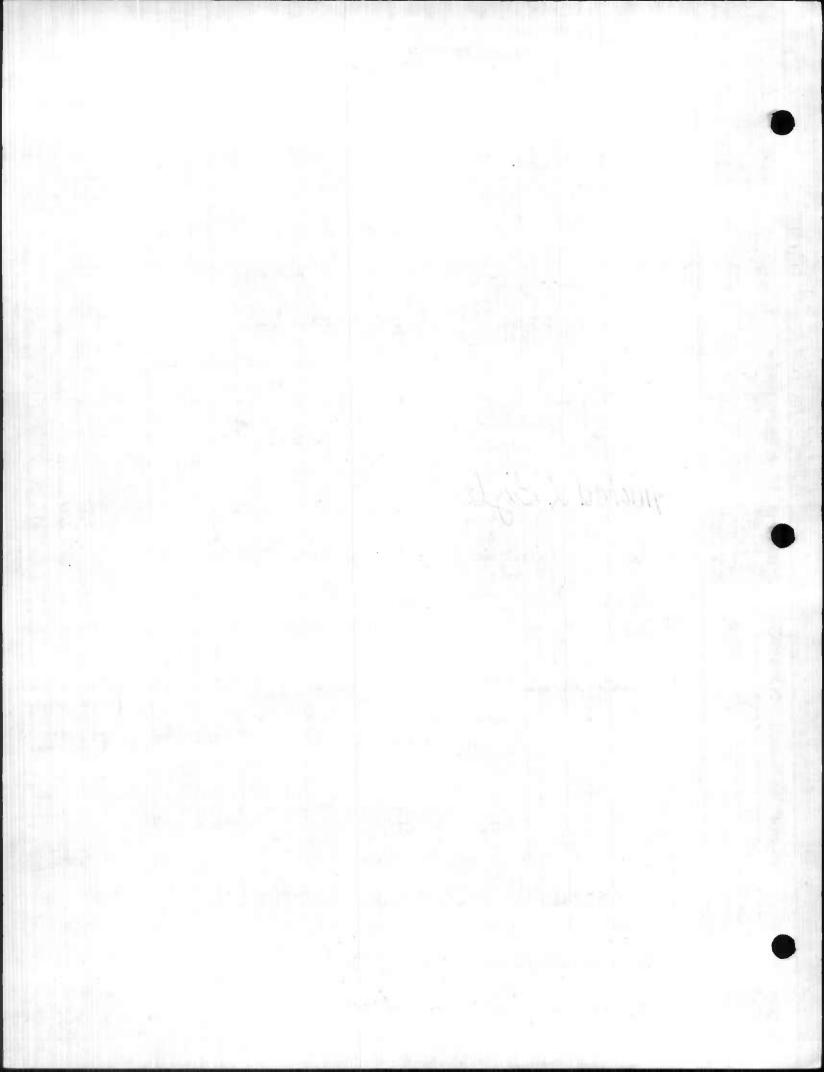
GREN BURNIE MD 210 61

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSRIGAL

32. Registrar's Signature

3011



Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

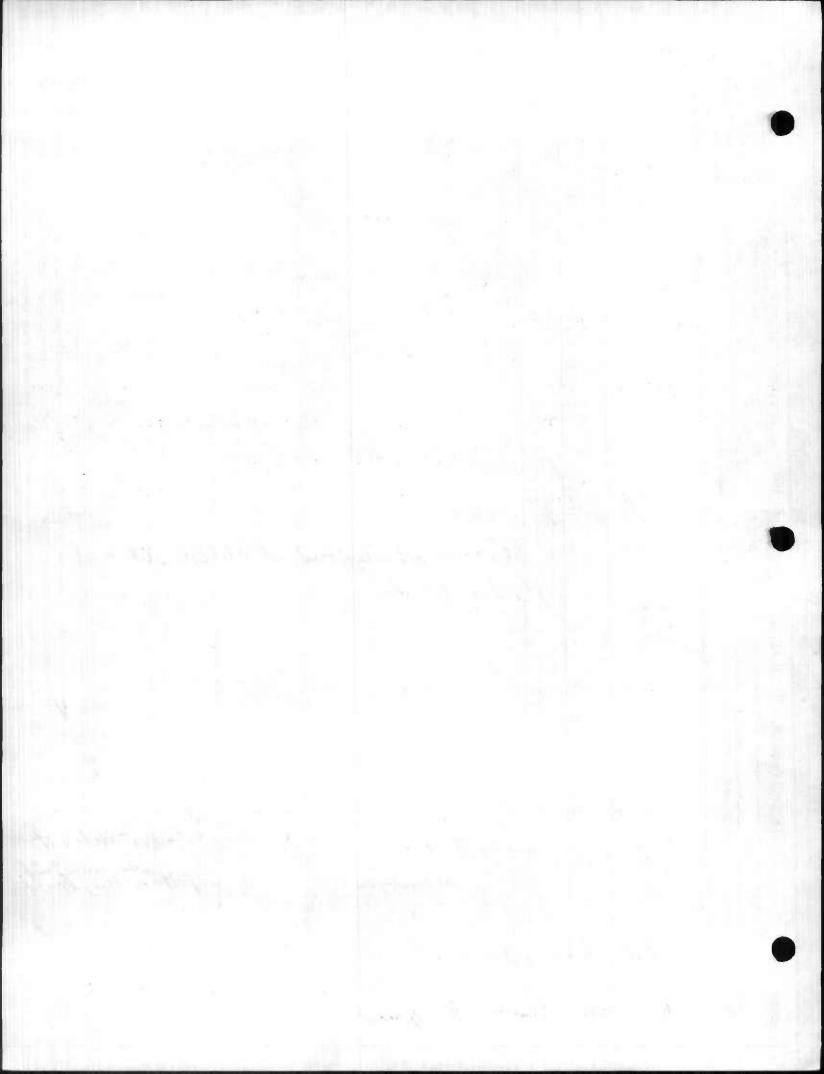
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

-188 LER			Certificate	e of Deat	h		Reg. No.	0 0	00001
1. Decedent's Neme (First, Middle, La	st)					2. Dete of D	eath	. 1	3. Time of Death
Emilv	Lena Mil	ller				Month	Dey	Year 999	10:55 A.N
la Facility Name (If not institution, giv				4b. City,	Town, or	Location of Dea	th 4c. Count		LU a Jul Bal
6400 Block of Ou	ad Avenue			Ba	Ltimo	ore		N/A	
5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	Months		er 24 Hrs	8 Date of B	irth	9. Birthple	ace (State or Foreig
214.00.4042	□м ХХГ	29	Yrs.	July 1100		Jan.2	1,1970	Mary	Mand
Usuel Residence of Decedent 10a, Stete 10b, County		10c. City, Town	n or Location					10	Od. fnside City Limit
MD N/A			imore						N⊟XYes 2 N
		Daic		0-4-			40- 01	140-40	11.11
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Lisa Diehl/ Mo									. 21224
20e. Method of Disposition	CHEL	20b. Place of	Disposition (Nam	ne of	Ave	Dete	20c. Location		
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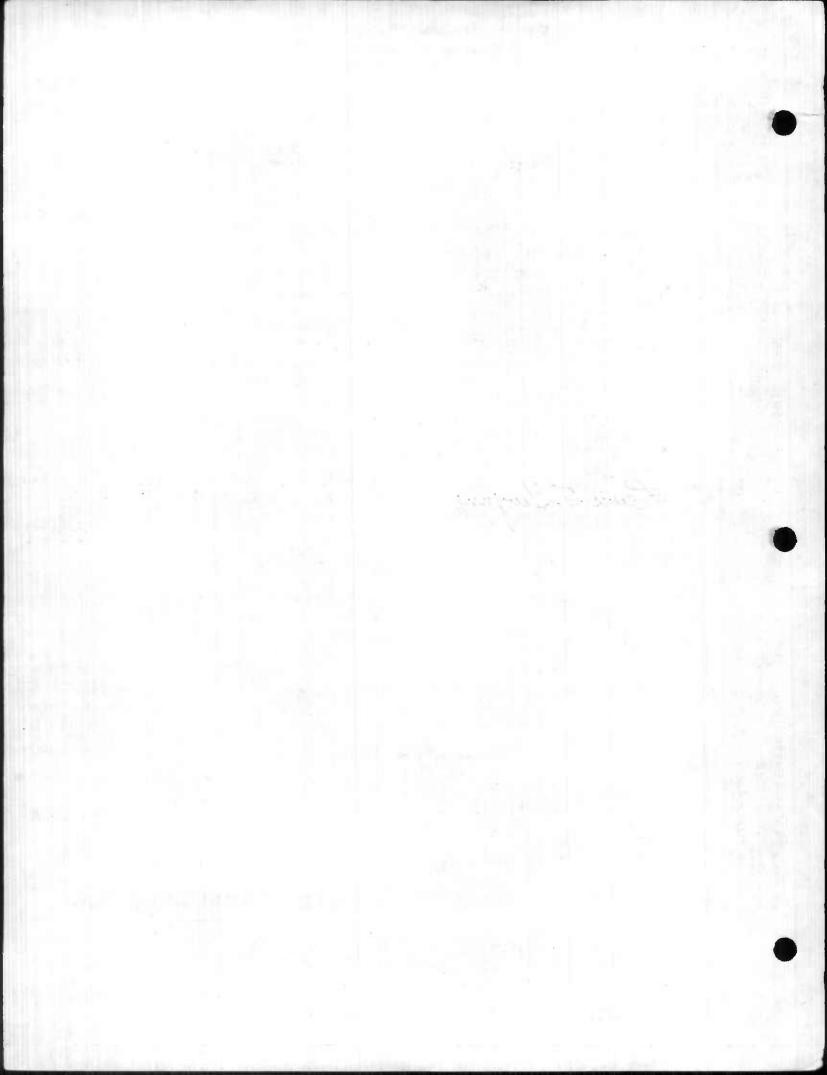


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2	RICHARD L.			JR.					E J. M		4,5	
	19a. Informent's Name/Ra	lationship	(Type, Print)		19b.	_		and Number or Ru	ral Routa Numb	ber, City or Town		
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Registrar

AUG 2 7 1999



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 06A **Physician** August Mary Catherine Parlett /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner Harford Fallston Fallston General Hospital Year If Under 24 Hrs. 8. Data of Birth Month, Pay, June 9, 5. Social Security Number 9. Birthplace (State or Foreign Maryland 7. Age (in yrs. last birthday) **Funeral** 1913 1 M 2CKE Yrs 216-50-3725 86 Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinet must be not find at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Middle River 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 6234 Ebenezer Road U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes ATNO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes % No Specify: white λq XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helldorfer Catherine William Drayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5921 Ebenezer Road, Baltimore, Maryland 21162 Roland R. Parlett (son) 20b. Place of Disposition (Nama of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 8/27/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Meth. Ch. Cem. 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Intarvai Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical (ang estive Heart 16 days Examiner Due to (or as e consequence of): Examiner Myorandial Infarct physician and the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Minknown sterasis 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed failure certificate has b lirector, page 2 s 210No or Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this funeral 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 1 Naturai 5 ☐ Pending 1 TYes 2 No investigation after death. 2 Accident Director: 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stele) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 24 hours after Funeral Dire-letaly filled in b Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completaly (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

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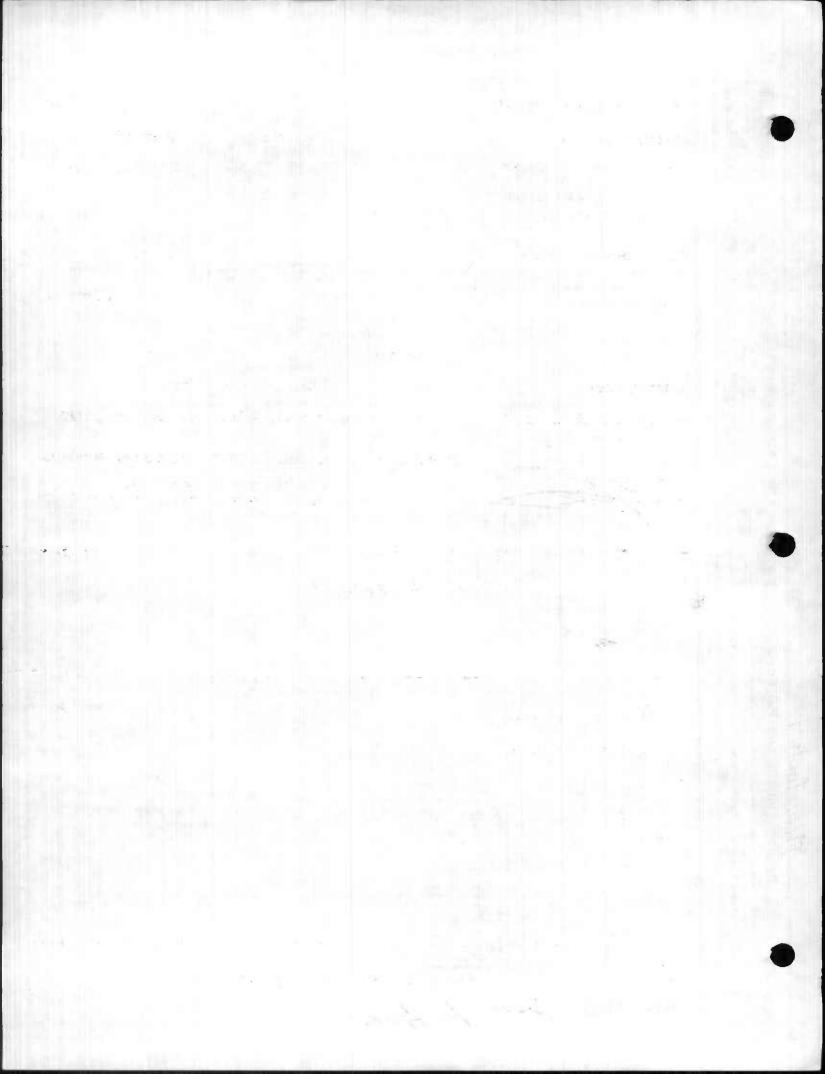
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29 1999

MARY PARIETA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev THOMAS E. POUGH 923 99 25 4a Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death MUnder 24 Hrs. 8. Dete of ANNE Arundal Arunde HOSPITA COUNTL Birthplece (State or Foreign Country) If Under 1 Year 8. Dete of Birth (Month, Day, Y 3-15-51 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Months Hours Min. 1 M 2 □ F Yrs. 148-40-2364 48 NJ Usual Residence of Decedent 10d. Inside City Limits 10s State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No MD. ANNE ARUNDEL SEVERN 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1900 GALETOWN DR. 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1∑EYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-SUPERVISOR OFFICE MOVERS 17. Father's Name (First, Middle, Last) 18 Mother's Neme /First Middle Maiden Surneme LEROY POUGH GWENDOLYN GALBRETH 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1900 GALETOWN DR. SEVERN, MARYLAND 21144 CHRISTINE GARRISON(SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State MD. VETERANS CEMETERY 8-30-99 CROWNSVILLE, MARYLAND 5 Other (Specify) 22. Name and Address of Fecility WM. REESE & SONS MORTUARY 21. Signature of Funeral Service License sese 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death om creatitis Immediate Cause (Finel disease or condition resulting in death) red Uai Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as e consequence of):

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar mast be notified at

parmit. Pages 1 and 2 should be filed within 72. Department of Health and Mentel hygiene. Important: if item 27 is marked other than "nation in long in light or other traumatic event, the Medical pages.

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

20 No 1 Yes 26. Place of Deeth (Check only one)

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1 Yes 2 No	Hospital: 175 Impatient 2	ER/Outpatient	3□ DOA Other:	4□ Nursing Homa	5 Residence	8 Other (Specify)
Manger of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury e Work?	t 28d	I. Describe how inj	ury occurred

27. М investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier transferriting Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifie

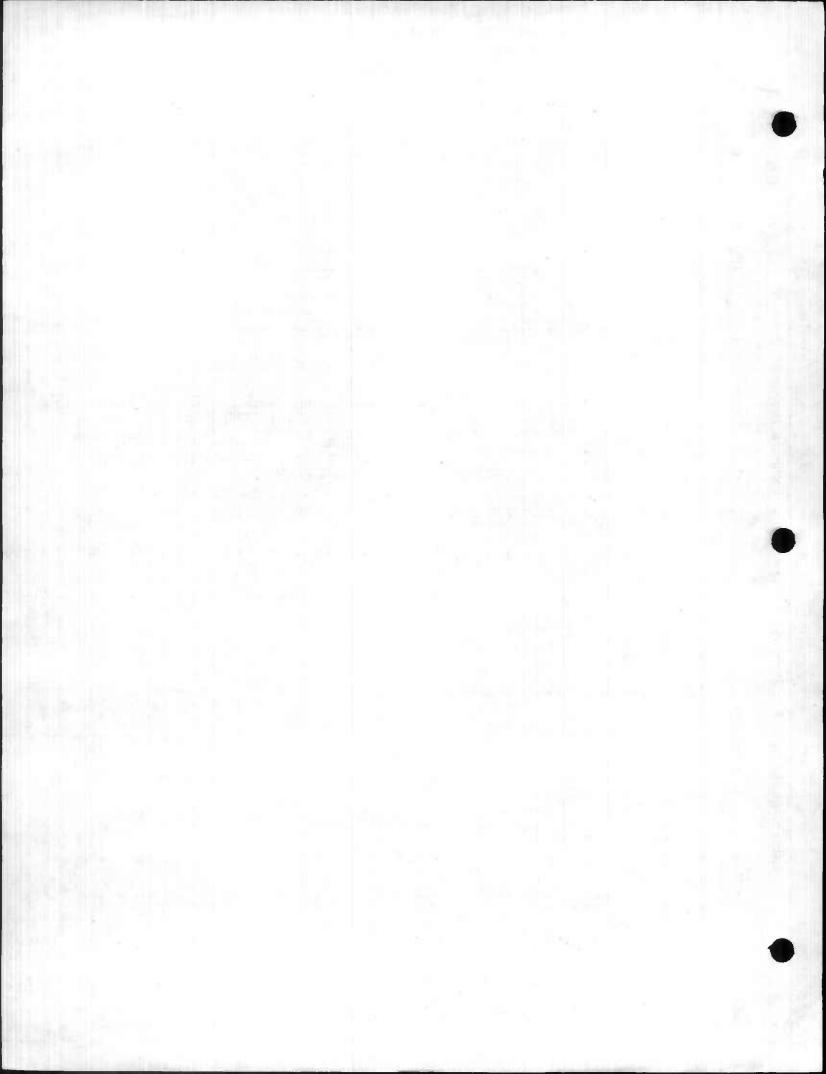
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

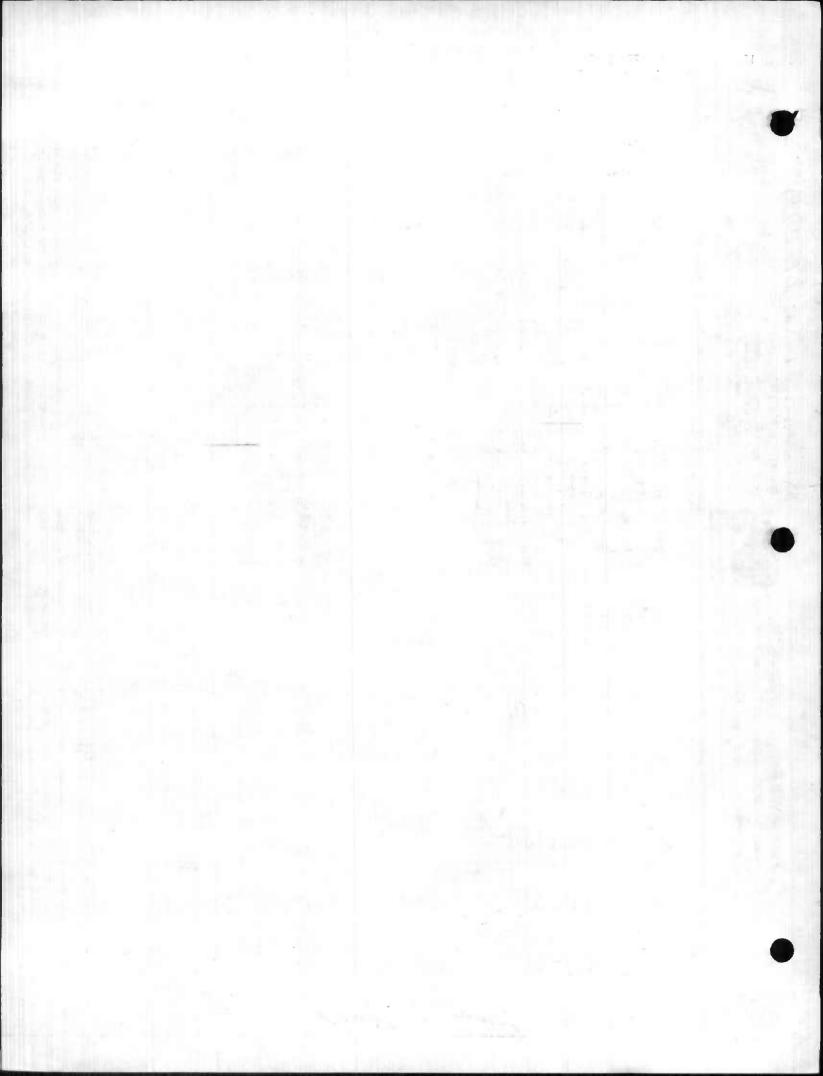
30 n /32. Registrar's Signature 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #20b PER FH G778 12/7/99 AH Certificate of Death 25005 Reg. No. Amended Item#19a perFH G774 8/31/99 FW 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Susan Ellen Richardson 1999 3:00 AM 23 August /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sex 1 M 2 K **Funeral** Daya Months Hours 212-32-1422 Director 97 Dec. 15 1901 Pennsylvania Usual Residence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits show 1 Yas 2 No Director 239-4 Baltimore Cockeysville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code or hams 23s or 300 Warren Road 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University 12 Book Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 8 Health and Mental am 27 is marked o John Cropper Wright Pages 1 and 2 should Rebecca Delphine MacMurray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Anna Belle James / Niece 541 Park Ave., Towson, MD 21204 If Itam 27 Date 8/20/90c. Location - City or Town, Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Funeral Service Lices 22. Name and Address of Facility Branqu Lemmon Funeral Home Clary 10 W. Padonia Rd., Timonium, MD 21093 23a. Part Enter the disease, or complications that caus shock or heart tailure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death **Physician** Immediate Canso /Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit that the death certificate be avacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Box 68760 Physician/Medical Due to (or as a consequence of) 897 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown signed bedet Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yea certificate Division of Vital Attending Physician: director. 25. Was case referred to medical 8 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Del 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 DiNatural 5 Pending 1 ☐ Yes 2 ☐ No deeth. 2 ☐ Accident investigation To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completaly filled in by the fi 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 52096 who completed cause of death (Item 23a) (Type, Print) 30. Name and add BM David Utzschneider, MD 6701 N. Charles St., Baltimore, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month AUGUST Dorothy Lorraine Sheeler 24, 1999 12:55 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 If Under 24 Hrs 8. Data of Birth (Month, Day, Yei June 15 1 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months 1□ M 2□ F Maryland 213-46-3794 54 1945 Usual Residence of Decedant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Lutherville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 604 W. Seminary Ave. 21093 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 □ Yas 2♥□ No If Yas, Giva Year or Datas: 14. Race - American Indian, Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Cotlega (1-4or 5+) Nursing Asst. Nursing n/a 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Joseph Barron Estelle Anna Mae Denmyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) John R. Sheeler, Jr./husband 604 W. Seminary Ave., Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 8/27/99 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21-Signature Funaral Sarvice Licente 22. Nama and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, bused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, arth lina. Clary 23a. Part / Enter the Usaesa, or complications not or shork, or heart fullura. List only ona cause on ea Approximete Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) DAYS PNEUMONIA Due to (or as a consequence of): SEPSIS DAYS Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): GOAYS HYPOXZA Due to for as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Examiner physician and s the burial-trans certificate be execu Box 68760, Physician/Medicai P.O. Division of Vital Records, þ Completed Be Certification: To this or Attending death. Director: To the Hospital or Att within 24 hours after do To the Funeral Direct completely filled in by I edicai

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Important: If Nem 27 is any injury or other

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25. Was case reterred to medical axaminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide

29a, Certifian (Check only

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1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar steted. 29b. Signatura and titla of cartifiar

CHAN

29c. License number 29d. Date signed (Month, Day, Year)

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AUGUST 1999

BALTZMORE

MARYLAND 21204

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print)

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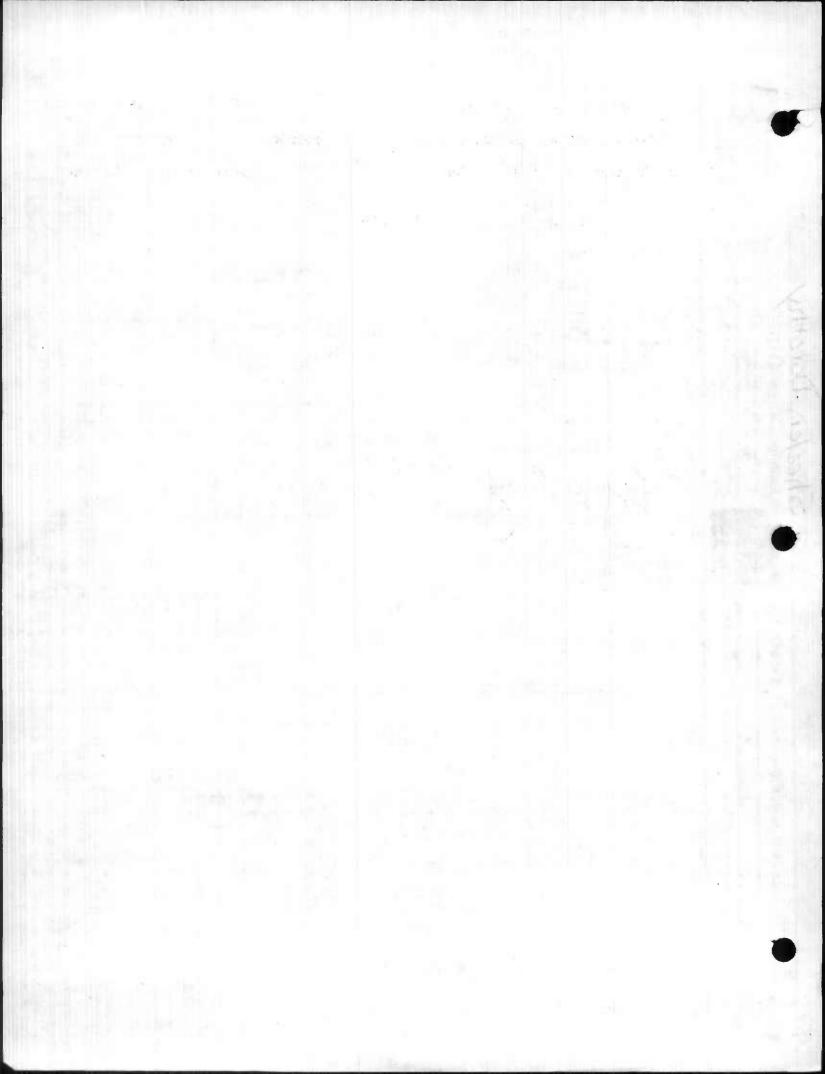
31. Data tiled (MANU Gay Year)

32. Registrar's Signeture

CHARLES

STREET

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 27, Margaret Elizabeth Safko 1999 AUG 3:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4662 Roundhill Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs Months | Devs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 XF 215-07-7320 85 Director 1914 APR 13, Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits than "natural", or flems 23a or 28a-f ahor the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4662 Roundhill 21043 Road USA death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelih and Mental Hygiene. Important: if Nem 27 is merited other than "natural", or hen eny Injury or other traumatic event, the Medical Exemption 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Joseph Armiger Rosa Birkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4662 Roundhill Road Ellicott City, MD 21043 John Safko/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/27/99 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Road Baltimore, 21228 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CMonthy 12 montia Examiner Due to (or as a consequence of): Examiner physicien end the burief-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown signed to þ 24b. Were autopsy findings available prior to completion of cause of deeth? been si 24a. Wes an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Box 68760. P.O. Records, of Vital this funaral Certification: Aftar Division Attending ne Hospital or Attending in 24 hours after death. The Funeral Director: Afte pletely filled in by the fun

Be 10

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

5 Pending investigation

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

12. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certify

29c. License number

Colon 6.c M 21084

30. Name and address of persoyl cause of death (Item 23a) (Type, Print) Gar Mari

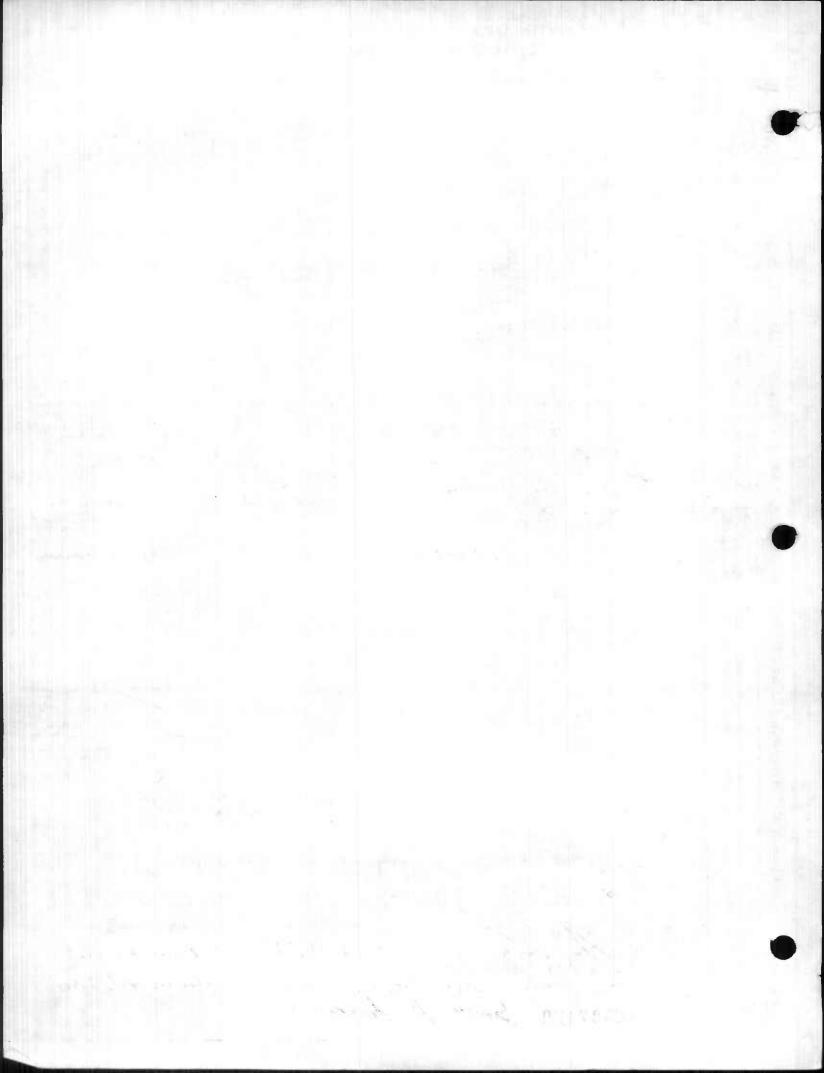
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31. Date filed (Month, Day, Year) AUG 27 1999 32. Registrar's Signature

State Registrar

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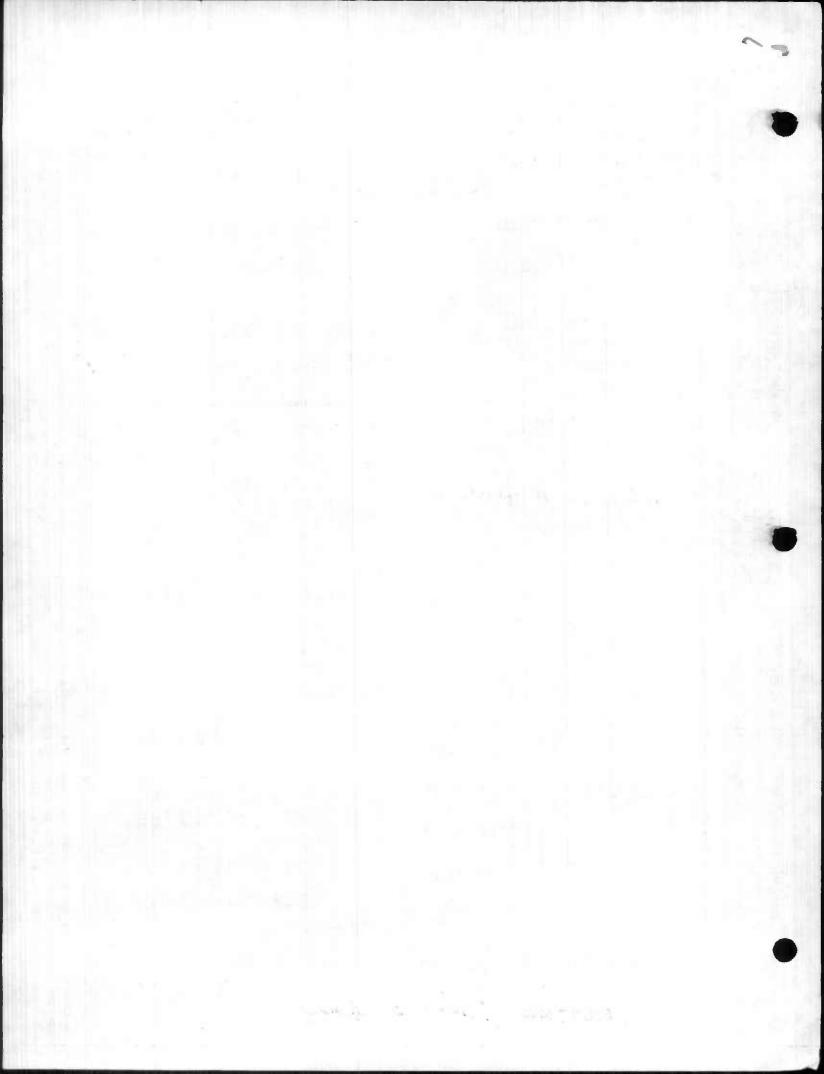
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State of Maryland / Department-of Health and Mental Hygiene

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Examiner	4e Facility Name (If not institution, g		r)			4b. City, Town,	or Location of Deeth	4c. County	oi Death	
	NORTHWEST HOSPIT	AL CENTER				RANDALL		BAL	TIMORE	
Funeral Director	5. Social Security Number 6 191-78-0626 Usual Residence of Decedent	Sex 7. A 1 □ M 2 🔀 F	Age (In yrs. last	V. Me	Under 1 Year onths Days	Hours N	lin. (Month, Da	th y, Year) 5, 1999	9. Birthplaca (S Country) Penns	tete or Foreign sylvania
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Dir.	10e. Street and Number			1	Of. Zip Code			10g. Citizen of V	Whet Country?	
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F. or he	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	?] No		s, specify Cub	Specify:	(Specify Yes or No serto Rican, etc.)	Specify	ck, White, etc.	
'natural', deal Ex	15. Decedent's	Education	1	6a. Decedent	s Usual Occur	ation		16b. Kind of B	usiness/Industry	
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and Mental is marked o aumatic eve To Be	Walter Lee Smi	th				Jeann	na Renee	Rothhau	pt	
and and	19e. Informant's Neme/Relationship	(Type, Print)		19b. Meiling A	ddress (Street	end Number or	Rural Route Number	er, City or Town,	Stete, Zip Code)	
if Health Item 27 other tr	Mr. and Mrs. Wal	ter Smith		9912 Ce			Randallst	own, MD	21133	
7	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3	□Damaual Irom Stat	20b. Pleci cemi	e of Disposition etery, cremeto	n (Neme of ry or other pla	ce)	Dete	20c. Location -	City or Town, Sta	ite
ary or	4 Donetion 5 Other (Spec		Lake	View N	Mem. Pa	rk	Aug 26	Sykesvi	lle, Mar	yland
Department of Important: If any Injury or price.	21. Signature of Funeral Service Lic	tors, I	nc.	2						
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nand Medical Kaminer Examiner	Immediate Cause (Final disease or condition resulting in death)	HIST		OID CA		YOPATH	IY			
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certificata rector, pag	25. Was case referred to medical					26. Place of	Deeth (Check only o			
	examiner?	Hospitel: 1 Inpa	tient 217 ER	Outpatient 3	DOA OH	vor:	g Home 5 ☐ Resi		er (Specify)	
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	1 Neturel 5 Pending 2 Accident investiget 3 Suicide 6 Could not determine	on be 28e. Plece of li			M 1 🗆	Yes 2□No	281. Location (Street and Numb	per or Rural Route	Number,
	29e. Certifier 1 Certifying F	hysician: To the bes	t of my knowled	dge, deeth occ	urred at the tir	ne, date end pl	ace, and due to the	cause(s) and me	enner as stated.	
he Fune plately fil edical	(Check only 2 Medical Exione)	miner: On the basis and manner:		and/or investi	getion, in my o	pinion, deeth o	ccurred at the time,	dete and plece,	and due to the ce	use(s)
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	30. Name and eddress of person who	completed cause of)		Baltimon			201



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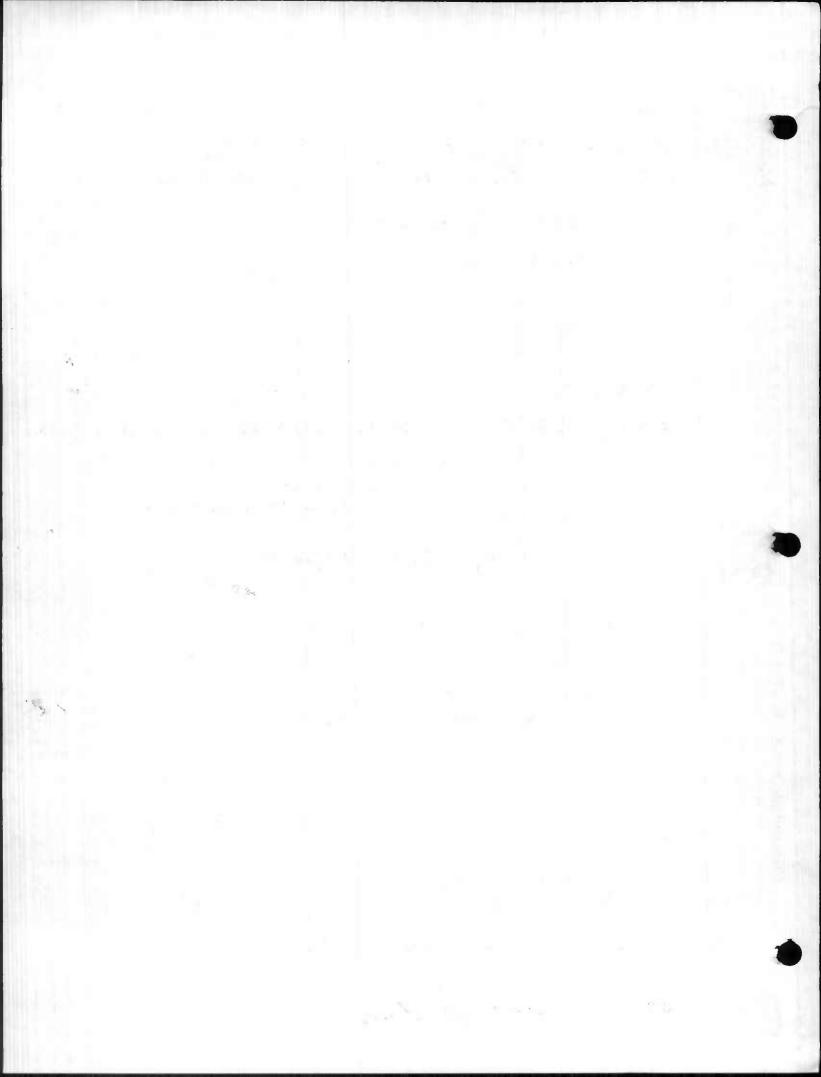
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Data of Daath **Physician** Month AUGUST 1999 MARY STANLEY 1:30 pm/Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** # 1D MIDDLE RIVER BALTIMORE 202 MIDDLEWAY ROAD 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F 215 12 7501 Director OCT 21 1923 MARYLAND Usuel Residenca of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MIDDLE RIVER t0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 MIDDLEWAY ROAD # 1D Funeral 21220 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOSPITAL 10 NURSES AID 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Be ALEXANDER STPCZUK HELEN UNK. 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any Injury or other trau SHARON RANDOL / DAUGHTER CHESTER, VIRGINIA 23831 6501 ARBOR LANDING DRIVE 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition Date 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Spacify) 8/26/99 BALTIMORE, MD METRO CREMATORY 22. Nama and Address of Facility
CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses rel enuor 1211 CHESACO AVE BALTO, MD 21237 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Injarval Batw Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) In forten Examiner Due to (or as a consequenca of): The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequença of): Box 68760. **Physician/Medical** Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Hypothyroidism, Osteo arthmete s been signed by should be detact 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? After this cartificata 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 Yes 2 No To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D. H. Shenbourne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9101 FRANKLINSQA. BALTO mD 2123> SHERBOURNE 32. Registrar's Signature State Registrar

DHMH 16 Bay 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of-Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) AUGUST ROBERT JOHN SALBERG 25, 1999 2:07 AM 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, giva street end number) VAMHCS FORT HOWARD DIVISION FORT HOWARD BALTIMORE If Under 1 Year | If Undar 24 Hrs. 7. Age (In yrs. lesf birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) Months Days Hours 1⊠M 2□ F Yrs. Feb. 16,1934 Chicago, 65 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore City 1 X Yas 2 No 10f. Zip Code 10g. Citizen of What Country? 21224 United States 3018 East Baltimore Street 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, Whita, atc. 1 X Yes 2 No
If Yes, Giva
Yeer or Detes: 1956-58 1 Navar Marriad 2 Married 1 ☐ Yas 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Retail Sales Salesperson Years 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Anne C. Hanson Joseph Brenald Salberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 201 Starry Road Sequim, Washington 98382 Mrs. Sally Britton/Sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ramovel from Stete 5 Other (Specify) Hilltop Service Corp. 8/26/99 Towson, Maryland 21. Signature of Juneral Service License 22. Nema and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222
Enter the Charge, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Appropriate the mode of dying, such as cardiac or respiratory errest. Approximete Interval Between Onset and Deeth PROSTATE CARCINOMA 1 YEAR Due to (or as e consequence of) BONE METASTASES 1 YEAR Due to (or es a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24e. Wes en eutopsy

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

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other

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permit. Pages 1 and 2.1 Department of Health at Important: If them 27 is any injury or other trau page.

Director

Funeral

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Completed

Be

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Hygiene.

and Mental markad

Baltimore, Maryland 21215-0020

/Medical

5. Social Security Number

331-28-5382

10e. Stete

Maryland

10e. Street end Number

20e. Method of Disposition

4 Donetion

Immediate Cause (Final

diseese or condition resulting in death)

Usuel Residence of Decedant

Examiner and I-transit physician a s the burial-Physician/Medical (0) attending 186 ō signed by the a by should I Completed has e 2 certificate has lirector, page 2 director, Be Lo Certification:

The law requires that the death certificate be executed Box 68760. Division of Vital Records, or Attending Physician: this funeral After n 24 hours after death. Funeral Director: Al death. Hospital

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Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Last Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medice 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? Naturel 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1🚰 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as steted 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one)

29c. Licansa number

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) JOHN LAH, MD--9600 NORTH POINT ROAD,

FORT HOWARD, MARYLAND 21052

29d. Date signad (Month, Day, Year)

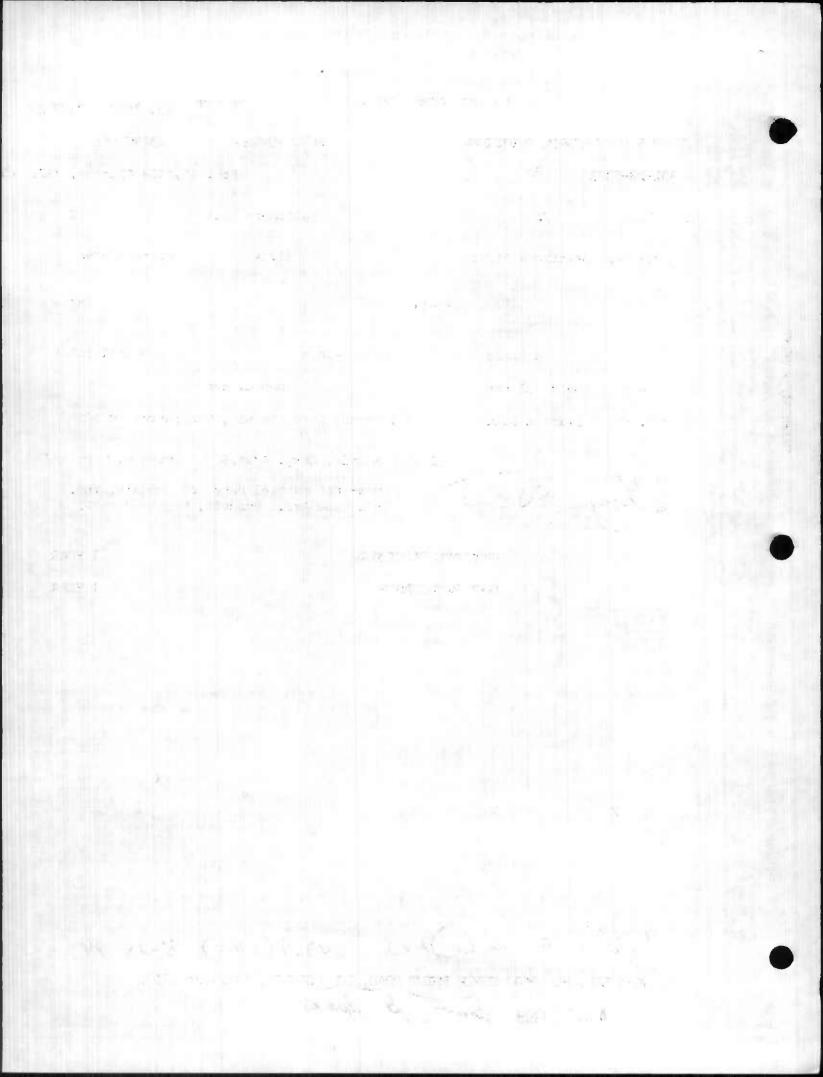
31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

AUG27

32. Registrar's Signature

Registrar

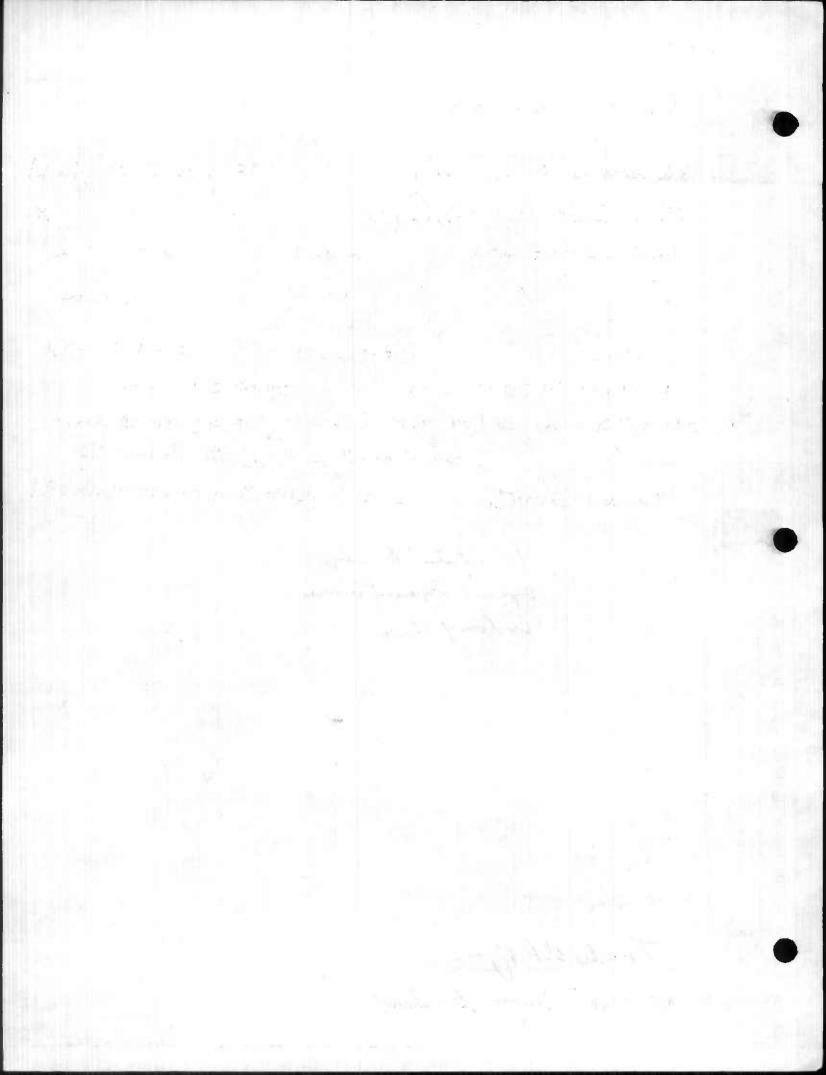


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ROBERT T. SOWINSKI

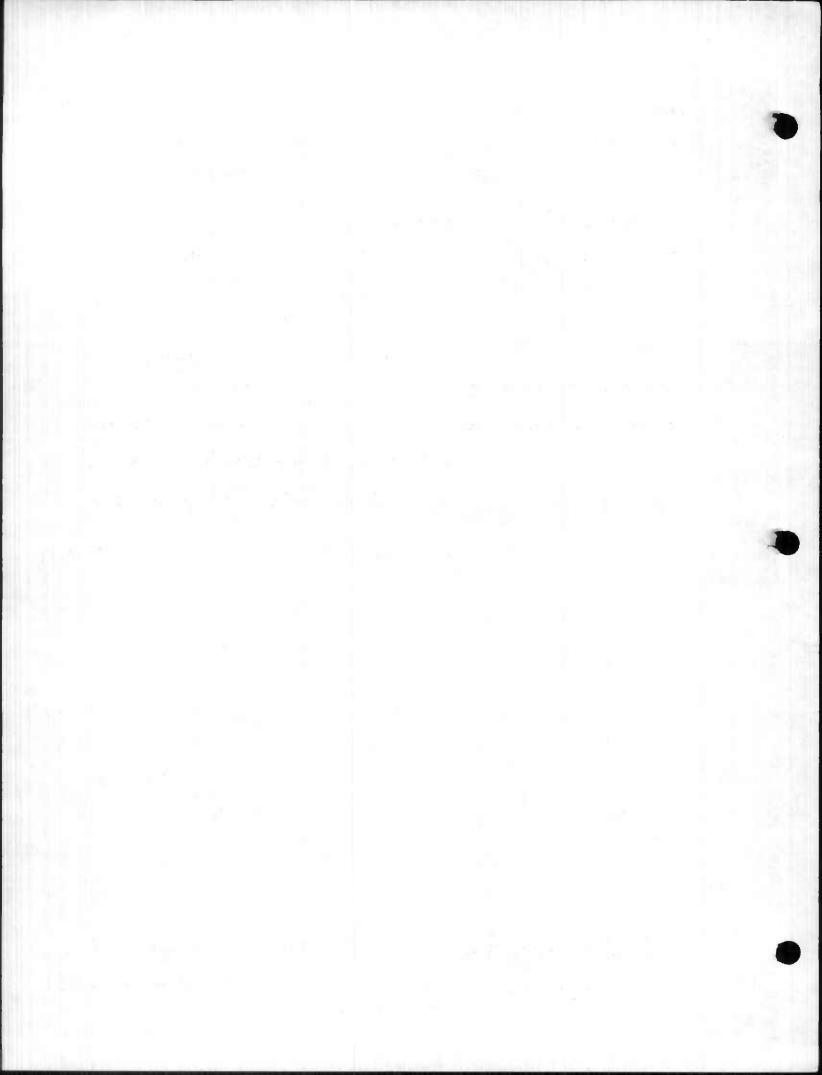
State of Maryland / Department of Health and Mental Hygiene

19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 4010 Todd Point have Edgewere, MD 21219 20a. Mathod of Disposition 1 Burial 2 (Accremation) 3 Removel from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, interest and Death Physician Medical Examiner Physician Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of):				Certifica	te of Death	F	leg. No.	9 21	6991		
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The state of the s		8232 OLD HARFORD	ROAD		PARKVJ.I.	LE	BALT	IMORE			
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	1	Decedent's Name (First, Middle,	(ast)		Certific	ale Of L	realli	2. Date of De	Reg. No.		3. Time of Death
Physici		Donald F.		Sr.				Month	Day	Year	9:50 A.M.
/Medio		4a. Facility Name (If not institution,				4b	o. City, Town, or Lo	August		inty of Death	
LAGIIIII	161	4729 Fawn Grove Roa	d				lesville		Harfo		
Funeral	П	5. Social Security Number		7. Age (In yrs.	Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D.	rth av. Year)	9. Birth	place (State or Fore
Director) Y	215-34-0336 Usual Residence of Decedant	X M 2U F	62	Yrs.			May 5,	1937	Balta	o.Co.,MD
show and at	5	10a. State 10b. County			y, Town or Location						10d. Inside City Limi 1 ☐ Yes 2 🕅
r 28a-f	Director	Maryland Harford 10e. Street and Number	1	Pyl	esville 10f.	Zip Coda		· '	10g. Citizen	of What Cou	
23a o	a D	4729 Fawn Grove	Road		21:	132			U.S.A.		
E E	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U			spanic Origin? (Spanic American, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White,	
Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Div <i>o</i> rced		2 No		2 ⊠ No	Specify:	, , , , , , ,		ecify:	ite
"natu Balless	Be Completed	15. Decedent's (Specify only highest	s Education grade completed)		16a. Decedent's U (Give kind of life. DO NO	sual Occupat	tion uring most of work	ing	16b. Kind o	f Business/In	dustry
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ant,	Ö	17. Father's Name (First, Middle, La			HOME DOTT		18. Mothar's Name	e (First, Middle			5
dic av	ToB	Bernard Christo	opher Sel	ing Sr.			Geneviev	e Kahle	er		
e un		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailing Addr	ess (Street al	nd Number or Run	al Routa Numb	per, City or To	wn, State, Zij	o Code)
er tr		Mrs.Marie Lisa S	Seling	(Wife)	4729 Faw		e Road	-	ville,		
or oth		20a. Mathod of Disposition 1 Burial 2 □ Cremation 3	3 □Removal from S		Place of Disposition (in termetery, cramatory of	Vame of or other place)	Date	20c. Locati	on - City or T	own, State
Jury		4 Donation 5 Other (Spe	ecity)		lAir Memor			/28/99	BelAir	,MD.2	1014
any in		21. Signature of Funeral Service Licensea 22. Name and Address of Facility E.F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087									
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buriel	calE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C								
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director, page	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Death				
director, pag	1: To	1 ☐ Yes 2 ☐ No 27. Mannar of Death	1 ∐ In 28a. Date o		ER/Outpatient 3□ 28b. Time of	DOA	4 LI Nursing Ho	me 5 Res 28d. Describe			(fy)
98	ation	1 Natural 5 Pending 2 Accident	(Month	h, Day Year)	Injury M	28c. Injury Work	7 as 2 □ No				
	8	3 Sulcide 6 Could no 4 Homlcide datarmin	led 288. Place	of Injury - At he	ome, farm, street, fac	ory, office			(Street and Ni wn, Stata)	mber or Rur	al Route Number,
by the funeral	1	4 <u></u>	Dulidio	ig, etc. (Specif	"			Ony or ro	wii, Olala)		
In by the funeral	Certification:		Phyaician: To tha b	sis ot examina	wledge, death occurr tion and/or invastigat	ad at the time on, in my opi	a, data and place, inlon, daath occurr	and dua to tha ed at tha time,	causa(s) and date and pla	mannar as a ce, and due t	stated. to the cause(s)
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stely filled in by the funeral	Medical Certifi	(Check only 2 Medical E)	and mann			29c. License	number		290. Date Si	gried (MOHIII),	Day, Year)
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filled in by the funeral	edicai C	(Check only 2 Medical Ex	Sedge 1	(Jun)			S46 Bluel,	22 01			

State Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 26003 Reg. No. 3. Time of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death Dev Year Month August George Ulbig Sr. 24, 1999 4c. County of Death 2:35 AM Α. 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Square Baltimore enter Hospital -osedale If Under 24 Hrs. 7. Age (In yrs. last birthday) 70 Yrs. Dete of Birth (Month, Day, Year) 9-15-28 If Under 1 Year Birthplaca (Stete or Foreign Country) MD 5. Social Security Number 216-24-2735 Months Days 1X M 2□ F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Mace Ave. 21221 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 X Yes 2 □ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Merried WW II 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Crane Operator Bethlehem Steel 17. Father's Neme (First, Middle, Last) Herman Ulbig Sr. 18. Mother's Neme (First, Middle, Maiden Sumeme) Mary B. Baker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1123 Mace Ave. Essex, MD 21221 19a. Informent'a Neme/Reletionship (Type, Print) Janet L. Ulbig / Wife 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Cedar Hill Cemetery 8-27-99 Glen Burnie, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Cvach/Rosedale Funeral Home Funeral Service Licen enibo 1211 Chesaco Ave. Rosedale, MD 23a. Part 1. Effer the disease, or complications that caused the dishock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Intervel Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? with Metastasis to Liven 1) Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No 1)☑Inpatient 2□ ER/Outpatient 3□ DOA 27. Manner of Death 26a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Name 23s or

b

altimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Pages 1 and 2 should be

sportant: If Item 27 is marked

Director

Funeral

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Completed

Be

2

21. Sig

Completed by Physician/Medical Examiner Certification: To

The law requires that the death certificate be executed hysician and the burial-transit certificate Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifica To the Hosp within 24 ho To the Fune completely fi

Be

edical

29a. Certifier (Check only one)

1 Netural

2 Accident

4 Homicide

29b. Signeture and title of certified

3 Suicide

6 Could not be determined

5 Pending investigation

28e. Plece of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

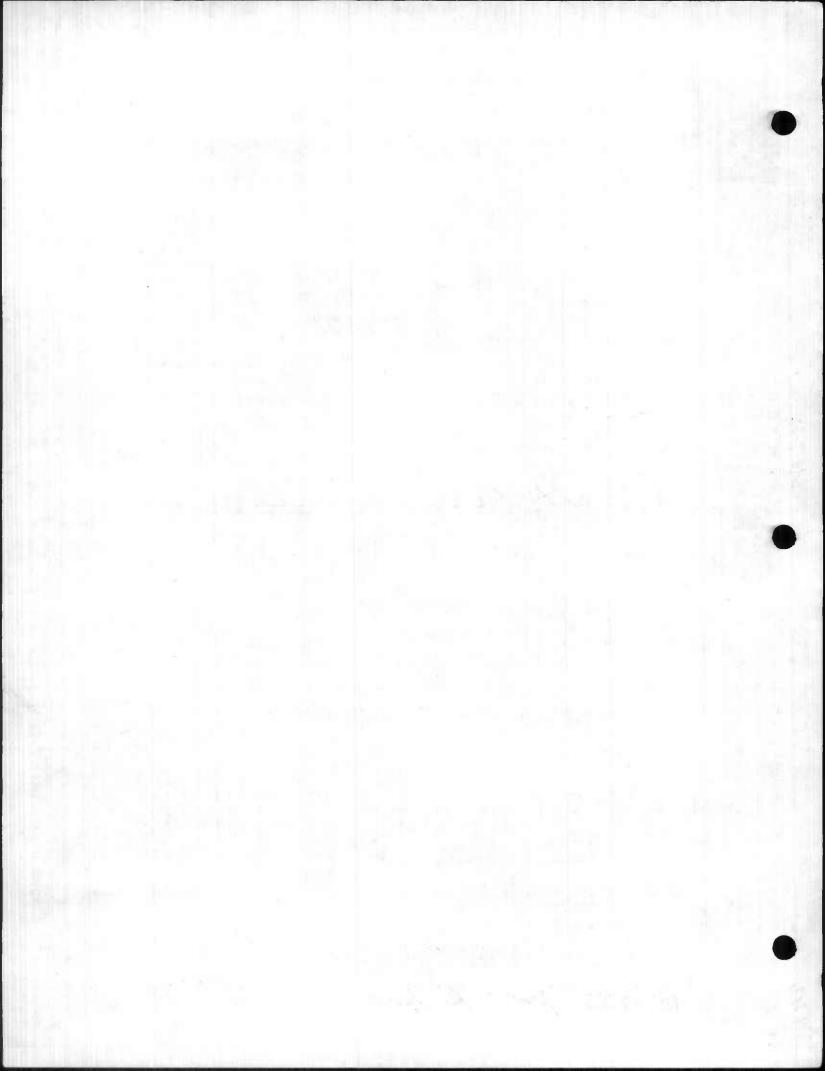
Upsh 62wde MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Drive Garyda Franklia Baltimore, m D. 2/23) 9000 e. Registrar's Spnature

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) Date of Death Franc S. Valentine 4a Facility Name (If not institution, give street and number) 4b. City, Town, or 4c. County of Death Levindale Hebrew Geriatric Center & Hosp. Baltimore Baltimore 7. Age (In yrs. last birthday) H Under 1 Year H Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 3,1905 Birthplace (State or Foreign Country) 1□M 21%F Yrs. 112-18-1221 94 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Owings Mills 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10729 Park Heights Avenue 21117 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Note Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerical Federal Reserve Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Unknown Raymond Edward Schreiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 425 St. Paul Street, Baltimore, MD 21202 Bertram Potempkin (Attorney) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition etery, cremetory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removel from State Metro Crematory 08/26 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensaa 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediete Cause (Final Cardiac disease or condition resulting in daath) acute gronary Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): ventilator Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? decub completion of cause of death? 1 Yes 1 Yee 2 No porosis 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Routs Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Completed 1

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(Check only one)

29b. Signatura end titla of certifier

Insul

Physician

/Medical

Examiner

Director

Funeral

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

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Physician /Medical

Examiner

Maryland 21215-0020

altimore,

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. Hypothyroidism 05/20 25. Was case referred to medicel axaminer? 1 Yes 2 No 27. Mannar of Death 1 Naturat 2 Accident 3 ☐ Suicide 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

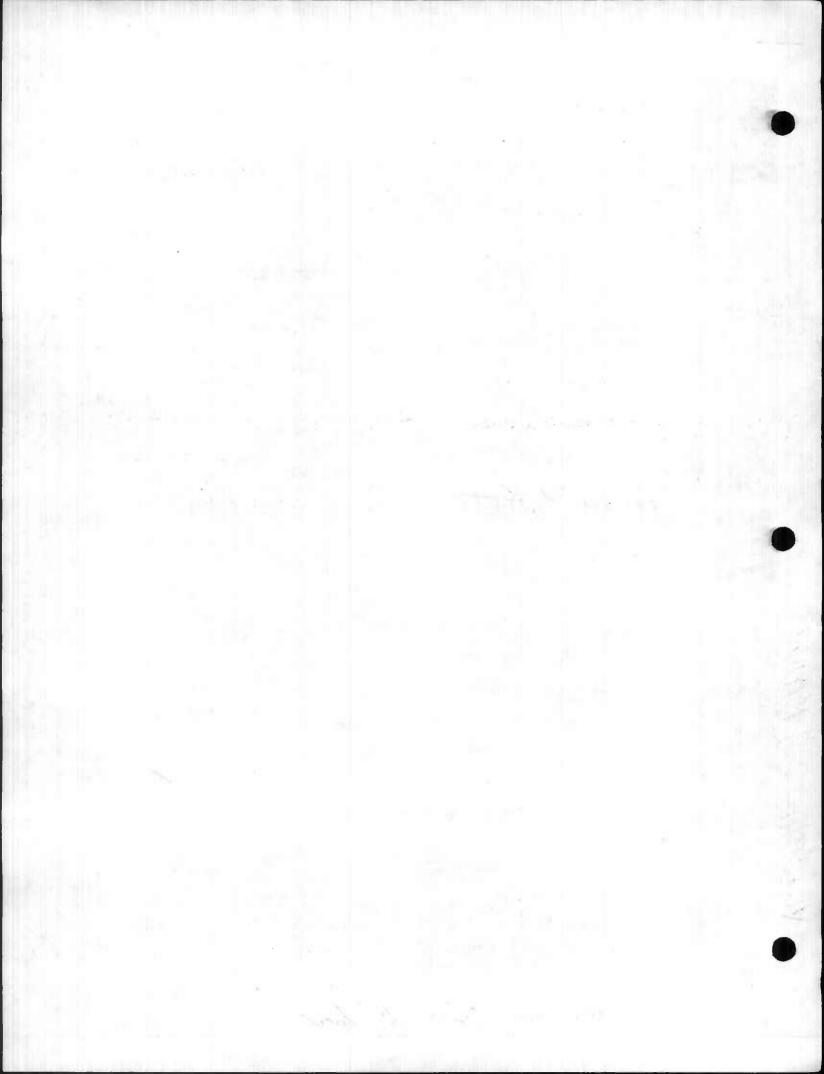
5-clvedove 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

11:44907

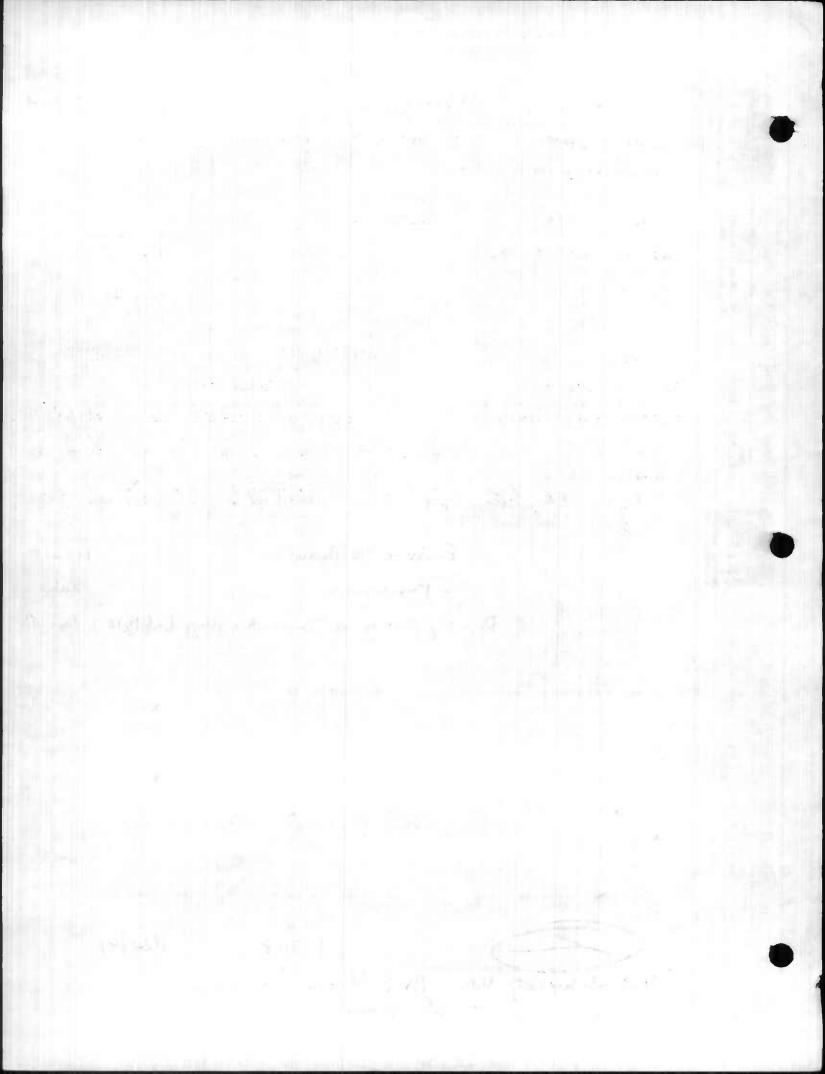


UEU #31 PE	R [VR G774 8/27/99 AH			Certificat	e of	Death		Reg. No.	9 26	995	
Physicia	an	Decedent's Name (First, Middle, Landson L	,					2. Date of De Month	Day	Year -	Time of Death: 47 PM	
/Medic		Clay Franklin 4e. Facility Name (If not institution, given	Welch				b. City, Town, or L	Augus			.91701	
Examin	er	Sinai Hospit						rore	4C. Court	y or Deam		
Funerai	_	5. Social Security Number 6. 3	Sex 7. Age	(In yrs. lest b			If Under 24 Hrs.	To Date of Di	th (9. Birthplace	(State or Foreign	
Director		215-14-6681	1 ∑ M 2□F	77	Yrs. Months	Days	Hours Min.	(Month, Di	1922	Marylar	nd	
and **		Usuel Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Location			-		104.1	nside City Limits	
r 28a-f show notified at	lo.	Maryland Baltimon	re	Pikes							Yes 2 No	
r 28a notifi	Director	10e. Street end Number			10f. Zip	Code			10g. Citizen of	Whet Country?		
23a or satt be c	a D	711 Templecliff H	Road		2120	8			U.S.A.	U.S.A.		
er dez Items Dec.ms	Funeral	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was Deced	ent of H	ispanic Origin? (Sp en, Mexican, Puerto	pecify Yes or No)- 14. Ra	ce - American Ir	ndian,	
amin	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: W	w II	1 ☐ Yes 2		Specify:	,	Specia			
shurs cal E		15. Decedent's E	ducetion		a. Decedent's Usua	I Occup	ation		16b. Kind of E	Business/Industr		
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or the	Completed	12 Years	2 Years				Press Ro	om	Newspay	wspaper		
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			me)		
at of a	2	Harry C. Welch	T - 1 D 1 D				M. Lilli					
Hoalth and sen 27 is ma other traum		19a. Informant's Name/Relationship	Wife)		b. Mailing Address 1 Temple						21208	
r other		Betty V. Welch (V	wile)	20b. Place	of Disposition (Nem	e of	T	Date		- City or Town,		
* * *		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1	ery, cremetory or or View Memo			8_26_99	Sulacu	1110 M	rvland	
important any injury once.		21. Signature of Funeral Service Lice	• •	Dake	22. Name en	Addre	ss of Facility		-		ir y rana	
Eag		1 COL	. Wayne Ost	arlino	Loring	Bye	rs Funer	al Dire	ctors, .	lnc. Marvlan	1 21133	
		23a. Part Enter the disease, or comshock or heart failure. List only	plications that caused t	he death. Do						App	roximete rvel Between	
Medical buyaniner and properties the private strength of the private strength	_	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Redo C	OVONOL Due to (or as a	consequence of):				H Sur	gery		
ding pl	Mec		d									
affor use es	Physician/Me											
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ate ha	EO.							1 🗆	Yes 2 No	1 □ Ye	a 219-No	
	Be	25. Was case referred to medical examiner?				_	26. Place of Dee	th (Check only	one)			
09 0	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Hopatien				4 Li Nuising H		dence 6 □Ot			
ctor: After y the funer	Certification:	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Dey	Year) 28b.	Time of Injury M	Bc. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how injury occu	rred		
by the	lfica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injur	y - At home, f	farm, street, factory		140 20.10		Street and Num	ber or Rural Ro	ute Number,	
od in by the	Sert	4 Homicide	building, efc.	(Specify)	,			City or To	wn, Stete)			
To the Funeral Director: After the completely filled in by the funeral	edicai (29a. Certifier (Check only one)	yelclan: To the best of niner: On the basis of e end manner state	xaminetion a	e, death occurred and/or investigetion,	t the tin	ne, date end place, pinion, death occur	and due to the	cause(s) end m date end plece,	anner es stated end due to the	ceuse(s)	
within 24 hours effer To the Funeral Dire completely filled in b	Me	29b. Signature and title of certifler			29c	Licens	e number		29d. Date signe	ed (Month, Dey,	Year)	
		Kach 1	veber D). O.	K	E	5-00	C	Augu!	st 23.	1999	
1		30. Name end address of person who	completed cause of dea	th (Item 23a)	(Type, Print))			
		_								9		
Stat		Karen Weber 31. Date filed (Month, Dey, Year)	completed cause of dea Binkin H	ospital	2401 W.B	lved	books	Battime	ne M.L.	1. 2/2	15	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Deeth 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** LUO 1999 rman /Medical 4b. City, Town, or Location of Ceath 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Battimore N/A 115 Me rose Ave Green E ono If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Under 1 Yeer Birthplece (State or Foreign Country) 5. Sociel Security-Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F 80 3, 218-09-1135 **Director** JULY Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow f is marked other than "natural", or items 23s or 28s-f show traumstic event, tra Machinal Expense results or nothing a 1 Tyres 2 No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizan of What Country? 10e. Street end Number 607 S. BELNORD AVE. 21224 USA Herra 23a permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Tyes 2 □ No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: ģ 3 Widowed 4 Divorcad WWII 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE WAREHOUSE WORKER 10TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) MARGARET DUVAL JAMES WESTKAMP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 0 3 0 19a. Informent's Neme/Relationship (Type, Print) 1100 DULANEY GATE CIRCLE, COCKEYSVILLE, GORDAN WESTKAMP/BROTHER 20b. Place of Disposition (Nama of 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST VA 5 8/26/99 OWINGS MILLS, MD 21. Signatur of Funeral Service Licenses 22. Nama and Address of Facility
CHARLES S. ZEILER any Ir &SON inske BALTIMORE, 6224 EASTERN AVE. 21224 MD. 23a. Pant. Empt the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or learn failure. List only one cause on each line. Approximate Interval Batween Onset end Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical 1-2whs Examiner Due to (or as a consequence of): Examine Neumania physician and the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Dementia unspeaked type Box 68760. Rapidly moves.

Due to (or as a consequence of): mogressive Physician/Medical Se Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yee 2 No 3 Probably 4 Unknown Records, b 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed been s hes certificate 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yes 2 KNo 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? or Attending 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es stated.

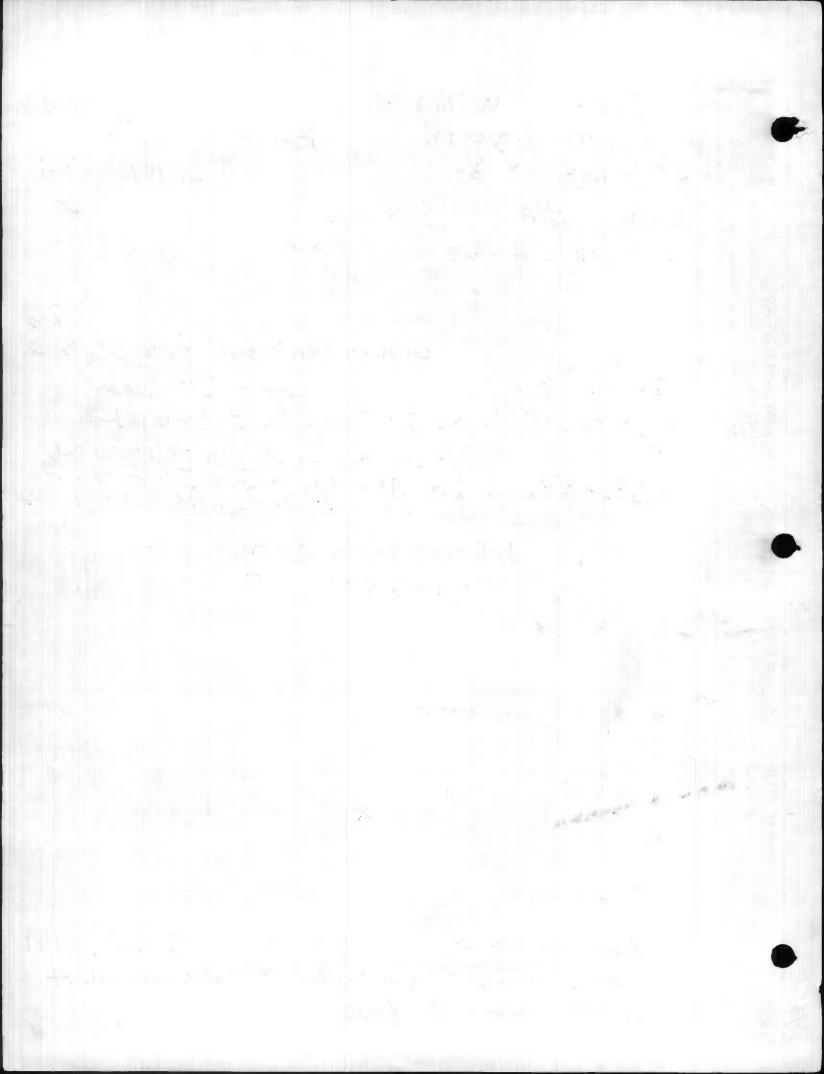
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete end plece, and due to the ceuse(s) end menner stated. edicai 29a, Certifier (Check only one) 29b. Signature and Idle of on 29c. Licensa number 29d. Date signed (Month, Dey, Year) 0 17118 8124 30. Name and address of person who comp cause of deeth (Item 23a) (Type, Print) Schwartz M.D. 21212 32. Registrer's Signetare Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death lliams Month Dat **Physician** di 25 99 a /Medical of Deeth 4a Facility Name (If not institution, give street and number) Examiner 9 If Under 1 Months 5. Social Security Number 6 Sex vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M M F Days 217-32-826 Usual Residence of Decedent Yrs Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, the Medical Examinal mans to another example. 10a State 10b. County 10c. City/Town or Location 10d. Inside City Limits 1 Yes 2 No MARYAN Director moR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? enne by Funeral - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 12. Was Decedent Everth U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2D No Baltimore, Maryland 21215-0020 Specify Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Building 10 18, Mother's Name (First, Middle, Malden Sumame) 17. Father Neme (First, Middle, Last) Be EmmA DR 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) ationship (Type, Print) 301 Ams 20b. Place of Disposition (Name of Dete Disposition 1 Burial 2 Cremation 3 Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service kilds de Ed mondsor 23a. Part1. Enter the disease, or complications that cause upe death. shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death **Physician** Pardiovascular /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner 9 0 attending physician and for use as the bunal-transit The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest bue to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the a 23b. Did tobacco usa contributa to the cause of death? Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 3 Probably 1 Yes 2 No þ 24b. Were autopsy findings avelleble prior to completion of cause of death? should I 24e. Was an autopsy performed? Completed After this certificate has funeral director, page 2 25 No 2/2 No 1 Yes 1 Yes or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 3DOA Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No death. n 24 hours after death.

Ne Funeral Director: A pletaly filled in by the f 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to tha cause(s) and manner stated. 29a. Certifier Medical completaly (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jacem Amatun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) to MD AMATUN TAEEM 501 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 7 1999 Registrar **DHMH 16 Rev 6/95**



			State of Mar	ylaria / i	Certifica			ATTO TV		g. No.	9 2	6998
	_	1. Decedent's Name (First, Middle, Last,		11					2. Date of Deat		Wall-	3. Time of Dec
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aminer		le. Facility Name (If not institution, giva	street and number)				4b. City, To	wn, or Lo	cation of Death		y of Deeth	_
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eral	5	5. Sociei Security Number 8. Sec	7. Aga (In yrs. lest bii	thdey) if Un Month	der 1 Yaer	If Undar	24 Hrs. Min.	8. Dete of Birth (Month, Dey,			lace (Steta or Fo
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Funeral Director		10e. Stete 10b. County	11		n or Location INGTON	DC					1	0d. Inside City Li 1X Yas 2
i e	1	10e. Street and Number			10f.	Zip Coda			1	0g. Citizen of	What Coun	try?
<u></u>		1708 FORT DAVIS ST	r S.E.		20020					UNITED	STAT	ES
je je	1	11. Marital Status	12. Was Decedant Eva Armed Forces?	ar in U,S.	13. Wes De	cedent of H	lispenic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Re	ce - Amaric	an Indian,
٩	3	1 ☐ Nevar Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yaar or Dates:			2 □XNo	Specify:	, rueito	nicen, etc.)		ock, White,	
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9		11	College (1-4or 5+)	A	IRLINE	ATTEN	DENT			AIR T	RAVEL	
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		BEVERLY POWELL /	ASHINGTON MD 20744									
	BEVERLY POWELL / DAUGHTER 803 NEWMONT ST. FORT WASHINGTON, MD 2074 20a. Method of Disposition 1 X Yourial 2 Crametion 3 Removel from Stete 20b. Place of Disposition (Nema of cemetery, cramatory or other piece) Dete 20c. Location - City or cemetery, cramatory or other piece)											wn, State
		1-A Buriai 2 ☐ Crametion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from Stete		. OLIVE			1	8-12-99	LIACI	II T M O TO	D.C. MC
once.	-	21. Signeture of Funeral Service License	90						FUNERAL		HINGT(DN DC
an al er	- 1	tmmediata Causa (Finel disaese or condition resulting in death)	A5	a to (or as a.	consequence	of):						
Examiner		Dua to (or as a consequence of): Atheroscleratic Cardiovascular Dua to (or as a consequence of):										
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78		resulting In death) Last	g in death) Last Due to (or as a consequence of):								į	
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To Be Completed by	2	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Dey Yo	- At homa, fa Specify)	Time of njury M mm, street, fect	28c. Injur Wor 1 [] fory, office	er: 4 Nu y et k? Yes 2 1	No State of the st	perform 1 Ye 1 Check only on ma 5 Reside 28d. Describe ho 28f. Location (St. City or Town	a) nce 8 Oti w injury occu reet end Num , Stete)	ther (Specif)	mpletion of causileath? I Yes 2 □ No I Route Number,

State Registrar

31. Data flied (Month, Day, Year)
AUG 1 2 1999



8 1/7

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

and the second second second

Please Type or Print in Biack indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene James Louis Alston AMEND ITEMS: #23 PART I, 27, 28A-F PER MED G774 8-30-99 Certificate of Death

f Death		3.	Tim	er of	Dea	th
1109.110.		1	13	4.3	1	1
Reg. No.	00	0	-14	0	0	-

9"	Series and the series
	Physician
	/Medical
	Examiner

1. Decedent's Name (First, Middle, Last) James Louis Alston, Jr. 4a Facility Name (If not institution, give street and number)

August 15, 1999

11:25 A.M.

Funeral

5529 Marlboro Pike #6 5. Social Security Number 15 M 2□ F 4b. City, Town, or Location of Death Capitol Heights

If Under 24 Hrs.

4c. County of Death Prince George's

Usual Residence of Deceden 10a State 10b County

8. Date of Birth (Month, Day, Year) 3-21-46 Months. Days Houra Yrs 10c City Town or Location

 Birthpiace (State or Foreign Country) WashingtonDC

Director

28a-f show

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"natural", or

nd 2 should be filed within 72 hou alth and Mental Hygiene. 27 is marked other than "natural or traumatic evant, the Medical E

Peges 1 and 2 should be found to the found of Health and Mental I in them 27 is marked of

permit. Pege Department of

or other

Examiner must be notified at

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

the Menyland

72 hours after

21215-0020

Baltimore, Maryland

Prince Georges MD.

Forestville

10d. Inside City Limita 1 Yes 2 No

10e. Street and Number

579-58-0097

5529 Marlboro Pike Apt.#6

20747

10f. Zip Code

If Under 1 Year

United States

16b. Kind of Buainess/Industry

20c. Location - City or Town, State

10g. Citizen of What Country?

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No Yes. Give Year or Dates:

53

7. Age (In yrs. last birthday)

 Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Raca - American Indian. Black, White, etc. Specify: Black.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer

Paving Company

17 Father's Name (First Middle Last)

21. Signature of Euneral Service Licenses

James Louis Alston Sr.

18. Mother's Name (First, Middle, Maiden Sumame) Bertha Jean Fells

Date

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) Barbara Alston spouse

5529 Marlboro Pike #6, Forestville, MD. 20747

20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other pleca) Lincoln Memorial

8/20/99 Suitland, MD.

22. Name and Address of Facility B.K.HENRY FUNERAL CHAPEL 420 H Street N.E., Wash., D.C., 20002

Physician /Medical Examiner

burial-tran

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page 2

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physician the buria

that the death certificate be executed

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Physicians

Attending

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death

after deat Director:

24 hours a Hospital

within 24 ho To the Fune completely fi

Box 68760,

P.O.

Records.

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Finel

disease or condition resulting in death)

NARCOTIC INTOXICATION

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line.

Due to (or as a consequenca of)

Due to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

2□ No

Approximate tnterval Between Onset and Death

2 No 25. Was case referred to medical 28. Place of Death (Check only one)

1 XYes 2 No 27. Menner of Death 1 Natural 5 Pending

28a. Date of Injury (Month, Day Year) investigation 8-15-99 6 Could not be determined

Hospital:

28b. Time of Injury UNKNOWN

28e. Place of tnjury - At home, farm, street, tactory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Tyes 2X No

Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 28d. Describe how injury occurred UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5529 MARLBORO PIKE, CAPITOL HEIGHTS,

29a. Certifier

2 ☐ Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) end menner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Sign and title of certifie

O.C.M.E.

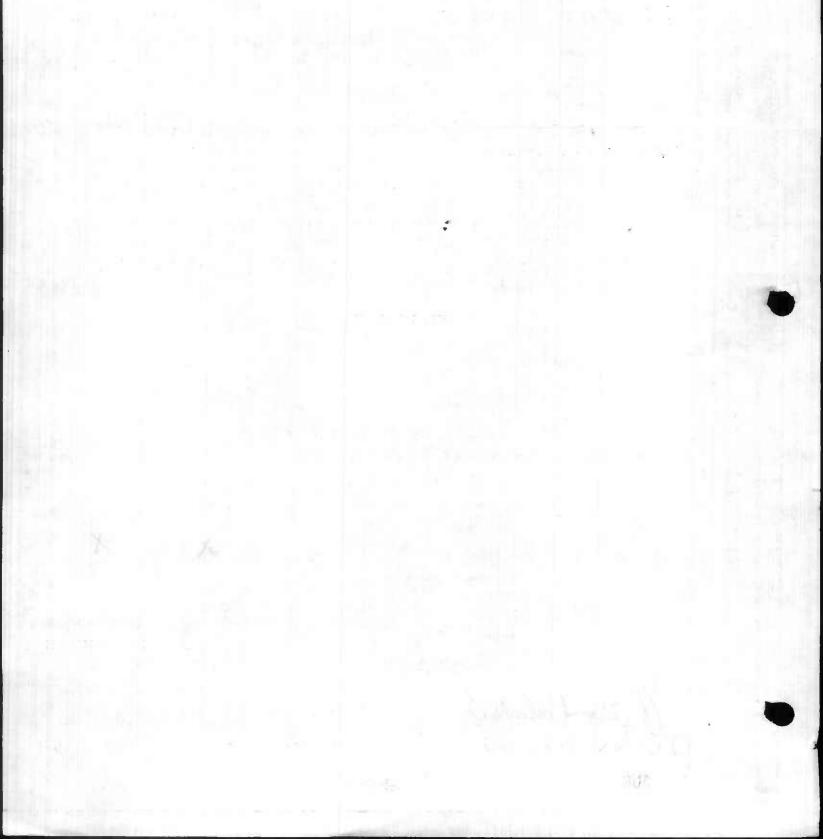
August 16, 1999

appress of person who completed cause of death (Item 23a) (Type, Print) MX KON Lesckt 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) AUG 2 0 1999 22. Registrar's Signature

HOME

State Registrar



Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show eny Injury or other traumatic event, fra Healtest Emeriner must be notified at 2006.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

				Departm	ent of H	lealth and I			ble.			
				Certific	ate of	Death		Reg. No.	9 /	700		
	The state of the s							ath Dey	Year	3. Time of De	eeth	
	Carl Jshonte B	lack, Jr.						t 07, 19	199	10:37	A.M.	
1. Decedent's Name (First, Middle, Last) 2. Date of Death Carl Jshonte Black, Jr. 4s. Facility Name (if not institution, give strear and number) Prince George's Hospital Center 4s. Cey, Town, or Localison of Death Cheverly 5. Social Security Number 579-02-2459 19 yrs. 10 yrs.		4c. County	of Death									
	Prince George's H	Hospital (Center			Cheverl	y	Princ	ce Geo	ath George's irthplace (State or Focunity) ash., D.C. 10d. Inside City L. 112 Yes 2D Country? d States nerican Indian, nite, etc. Black s/Industry e 2ip Code) 744 or Town, State n, MD Come 20019 Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal Approximate Intervel Betwee Onset and Deal		
				Mont			(Month, Da	y, Year)				
	Usual Residence of Decedent						Jane	0 1200	nas	Mag Dat		
	10a. State 10b. County		10c. City, Tow	n or Location					1	Od. Inside City I	Limits	
5	Virginia			Ric	hmond					1 Yes 2	□No	
5				10f.				10g. Citizen of \	What Cour	itry?		
	306 W. Charity	St.			23	220		Un	ited	States		
	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	? No				pecify Yes or No o Rican, etc.)	- 14. Rad Blac Specify	ck, White,	etc.		
3	15. Decedent's Ed	lucation	16a.	Decedent's L	Jsuel Occup	ation		16b. Kind of B	usiness/Inc	dustry		
2			5.1)	(Give kind of life. DO NO	work done Tuse retire	during most of wor d)	rking					
5		College (1-4or	5+)	Coo	k			Pri	vate			
						18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)			
	Carl Randolph B	lack				Tanya	a Patric	ia Boon	e			
**	19a Informant's Name/Relationship (Type Print)	196	Mailing Add	rass /Straat	and Number or Ru	iral Route Numb					
		rather				I., FL. V						
	1 ☐ Burial 2 ☐ Cremation 3 ☐			ry, crematory	or other pla	ce)	Date	200. Location	City of 10	WII, State		
	4 □ Donation 5 □ Other (Specify	1)	Lee	's Cre	mator	y 8	3/14/99	Cli	nton,	MD		
	21. Signature of Foheral Service Licen	Store of	TIT									
_	23a. Part1. Enter the disease, or comp	olications that cause	d the death. Do	not enter the r	node of dyi	ng, such as cardied	or respiretory a	rrest,		Approximete		
	Immediete Cause (Finel disease or condition			or ear	TORSO	AM GU	MASTU	OUND TO		Onset and Dea	ath	
5			Due to (or as a	consequence	of):				1			
		b. 64			4				i			
	if any, leading to immediate cause. Enter Underlying	•	Due to (or as a	consequence	of):							
	that initiated events		Due to (or as a c	consequence	of):							
		4							1			
	_	0.							1			
	Part II. Other algnificant conditions or	ontributing to death	out not resulting in	n the underlyin	ng cause giv	ren in Pert I.		1/				
-			3				24a. Was	en autopsy med?	av	ailable prior to		
							16	Yes 2□No	of	death?		
	25. Was case referred to medical					26. Place of Dec	oth (Check only o	one)				
	examiner? */CAYes 2 No	Hospital: 1 Inpat	ent 2 ER/Ou	tpatient 3	DOA Oth	er: 4 Nursing H	iome 5 Resi	dence 6 Oth	er (Specif	y)		
	27. Manner of Death	28a. Dete of Inj (Month, D	ury 28b. 1	Time of	28c. Inju	y at		how injury occur				
	1 ☐ Naturat 5 ☐ Pending 2 ☐ Accident investigation	0 ~	-90 1.0	njury M		Yes 2 No	SWOJE	a my	SSW	01.		
	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, fa lc. (Specify)	rm, street, fac	ctory, office		City or To				M	
Caroli Col micanoli:	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☑ Medical Exem	reician: To the best iner: On the basis of	of my knowledge	, death occur	red at the tir	ne, date and place	, and due to the	Cause(s) and mandale and place	anner as s	tated.	, 60	
j	one) 20 medical Exam	and manner s	ated.	an mastige	TOTAL RETRIENCE	PHINOIL OF BUILDING	ried at the time,	oate and place,	ario due lo	uno CEUSO(S)		
	29b. Signatura and title of certifier				29c. Licens	e number		29d. Date signe	d (Month	Day Veerl		

To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed

A Ry M TO A . (C)

31. Date filed (Month, Day, Year)

AUG 1 1 1999

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) August 09, 1999

cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29b. Signatura and title of certified

37. Registrar's Signature

